

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9954

CERTIFICATE OF DEATH

09907

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>6 mo 29</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kensington</u>		<u>1536-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>3403 University Blvd Wn</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Northcutt Adams</u>				4. DATE OF DEATH (Month) <u>9</u> (Day) <u>26</u> (Year) <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>(Widowed)</u>	8. DATE OF BIRTH <u>9/9/1900</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>H. W. Northcutt</u>				14. MOTHER'S MAIDEN NAME <u>Sally Outlaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>237-18-0547</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) Myocardial Infarction</u>						<u>2 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(B) Severe generalized Arteriosclerosis</u>						<u>over 5 yrs</u>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>(C) Pulmonary TB, inactive. Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-29-60</u>, to <u>9-26</u>, 19<u>60</u>, that I last saw the deceased alive on <u>9-26</u>, 19<u>60</u>, and that death occurred at <u>8:25 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>		ADDRESS (Street, city, town, state) <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>		DATE SIGNED <u>9.27.1960</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Transit</u>		DATE THEREOF <u>9/28/60</u>		NAME OF CEMETERY OR CREMATORY <u>Holly Springs</u>		LOCATION (City, town, or county) (State) <u>Holly Springs, N. Carolina</u>	
24. REC'D BY REGISTRAR <u>SEP 29 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montgomery Ave., Rockville, Md.</u>			

10303

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Form No. 10

TO BE FILLED OUT BY THE REGISTRAR

STATE OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RECEIVED

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9940

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09908

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1932 Sulphur Spring Rd.		d. STREET ADDRESS 1932 Sulphur Spring Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Augusta Edna Ammond		4. DATE OF DEATH Month Day Year Sept. 24, 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Link		14. MOTHER'S MAIDEN NAME Annie C. Benner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO.	
17. INFORMANT Caroline Weidenhammer		Address 1932 Sulphur Spring Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast c DUE TO metastases to lungs. Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic Cardiovascular c failure		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City as town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 29 to Sept 24 19 60 that (I) met last saw the deceased alive on Sept 23 19 60 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl Pass		22b. DATE SIGNED 9-26-60	
22c. PHYSICIAN'S NAME (Type) Earl I. Pass, M.D.		22d. ADDRESS 4001 Wilkens Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Collier S. K...	

2

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9955

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09909

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b 12 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Overbrook Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHRISTIAN First ARCHIBALD Middle ARCHIBALD Last				4. DATE OF DEATH SEPT 16 1960 Month SEPT Day 16 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 25, 1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. CLERK				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME SAMUEL ARCHIBALD				14. MOTHER'S MAIDEN NAME LOUISE REMMERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-09-2929		17. INFORMANT Mrs. ALMA ARCHIBALD Address 301 OVERBROOK RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rt. Lung 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1960 to Sept 16 1960 , that (I) (we) last saw the deceased alive on Sept 16 1960 , and that death occurred on Sept 16 1960 at 4 A M, from the causes and on the date stated above.							
22a. SIGNATURE Laurence C. Post				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-16-60	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST				22d. ADDRESS 6805 York Rd. Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 19, 1960		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION (City, town, or county) (State) ANNE ARUNDEL County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & Sons Co. ADDRESS 4905 YORK RD, BALTO				25a. REC'D BY REGISTRAR SEP 19 '60 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

100000

MADE IN GERMANY

100000

100000

100000

100000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9956

CERTIFICATE OF DEATH

69910

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>		d. STREET ADDRESS <i>2901 V. Laet Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Philip</i> Middle <i>Asbell</i> Last <i>Asbell</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>27</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March-1878</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Booker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>20</i>		17. INFORMANT <i>Samuel J. Asbell - 4306 Garrison Blvd.</i> Address <i>Cpt D</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>442X</i> DUE TO <i>Uremic Acidosis,</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> (b) } (c) }			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks.</i> <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Cardiovascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1954</i> to <i>Sept 27 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 25 1960</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Hyman Schiff M.D.</i>		22b. DATE SIGNED <i>9-28-60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>4023 Fallstaff Road, BaeF 15.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept 29 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sharon Zion</i>	23d. LOCATION (City, town, or county) (State) <i>Redale, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Zernow & Biss</i> ADDRESS <i>6010 Rust Road</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 3 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first section of the charter is the preamble, which sets out the purpose and scope of the document.

2. The second section is the body of the charter, which contains the main provisions and articles.

3. The third section is the concluding section, which contains the signature and date of the charter.

1

4. The fourth section is the final section, which contains the signature and date of the charter.

5. The fifth section is the final section, which contains the signature and date of the charter.

6. The sixth section is the final section, which contains the signature and date of the charter.

7. The seventh section is the final section, which contains the signature and date of the charter.

8. The eighth section is the final section, which contains the signature and date of the charter.

9. The ninth section is the final section, which contains the signature and date of the charter.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 3 File 6271 9-14-60 et

69911

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 24 North Rosedale Avenue	
3. NAME OF DECEASED (Type or print) Elsie Marie (Banglesdorf)		4. DATE OF DEATH Month September Day 11 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX		10b. KIND OF BUSINESS OR INDUSTRY Brush Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Daubert		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-14-6066	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Corpulmonale DUE TO (c) Persistant ostium secundum		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 26, 1956 to Sept. 11, 1960 , that (I) (we) last saw the deceased alive on Sept. 11, 1960 , and that death occurred at p. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 9-12-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/1960	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edlsworth Armacost		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
ADDRESS Edlsworth Armacost-4600 Liberty Hgts. Ave.		25b. REGISTRAR'S SIGNATURE Charles S. Krand	

1100

1100

(M)



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARDIAN STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09912

9958

1 PLACE OF DEATH a. COUNTY BALTO 28				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES CO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONVILLE				c. LENGTH OF STAY IN 1b 7 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS MAPLE AVE			
3 NAME OF DECEASED (Type or print) First JENNIE Middle - Last BELL				4. DATE OF DEATH Month SEPT Day 24 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1873		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? RUSSIA	
13. FATHER'S NAME Ira Thompson				14. MOTHER'S MAIDEN NAME Elsie Christiana			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 1		17. INFORMANT Mr. HOWARD FIELD SON IN LAW		Address MAPLE AVE BELTSVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) VASCULAR DISEASE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 11, 1953 to SEPT. 24, 1960 that (I) (we) last saw the deceased alive on SEP. 24, 1960 and that death occurred at 5 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Jose R. Arizaga				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA				22d. ADDRESS SPRING GROVE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial		23b. DATE THEREOF 9/28/60		23c. NAME OF CEMETERY OR CREMATOR Rosendale Plains		23d. LOCATION (City, town, or county) (State) Rosendale N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

Removal - Burial

9/28/60

Rosendale Plains

Rosendale

N. Y.

F. Gasch's Sons

Hyattsville, Maryland

DATE SEP 27 '60

Arthur S. Kenna



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

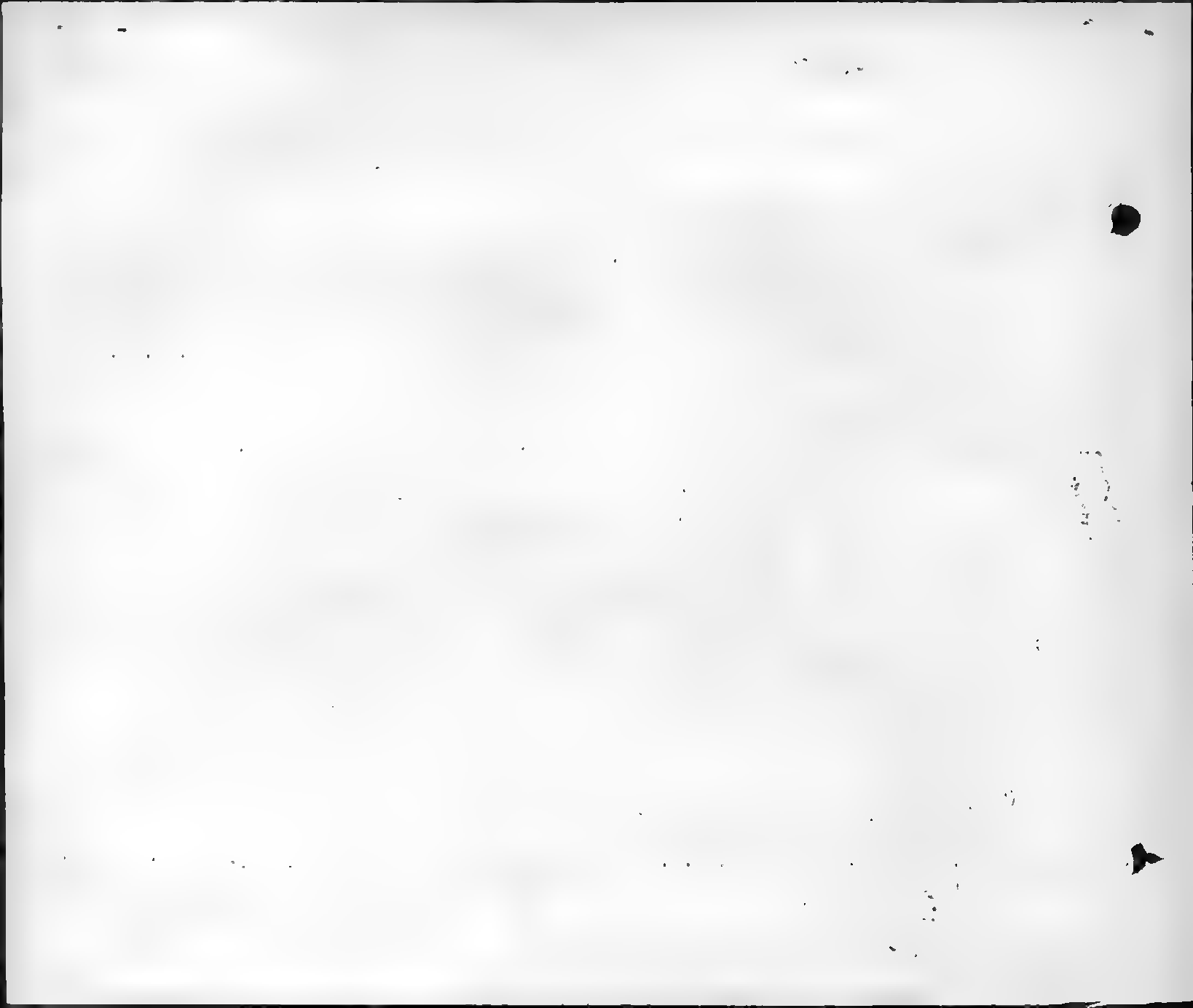
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
B
M
9959
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09913

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 20 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
3. NAME OF DECEASED (Type or print) First PERCY Middle M. Last BELL				4. DATE OF DEATH Month September Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1897	
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 6 Days 20 Hours 12 Min 45		11. IF UNDER 24 HRS Months 6 Days 20 Hours 12 Min 45		12. IF UNDER 1 YEAR Months 6 Days 20 Hours 12 Min 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor Retired				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Percy Bell				14. MOTHER'S MAIDEN NAME Florence Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 220-03-522			
17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. FT. HOWARD DIVISION				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM WITH PULMONARY INFARCTS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE HEMORRHAGIC PANCREATITIS DUE TO (c) 20 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 HOURS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 12:45 P p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (if (this hospital) attended the deceased from August 31, 1960 , to Sept. 20, 1960 , that (if (we) last saw the deceased alive on Sept. 20, 1960 , and that death occurred at 12:45 P M, from the causes and on the date stated above.							
22a. SIGNATURE FREDERICK S. DONALDSON, M.D.				22b. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF SEP 25 1960			
23c. NAME OF CEMETERY OR CREMATORY Carroll's Church Cem				23d. LOCATION (City, town, or county) (State) Calvert County, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE LeRoy Berry				25a. REC'D BY REGISTRAR SEP 26 60			
25b. REGISTRAR'S SIGNATURE Huntingtown, Maryland				25c. REGISTRAR'S SIGNATURE Arthur S. Howard			

22b. DATE SIGNED
9/21/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

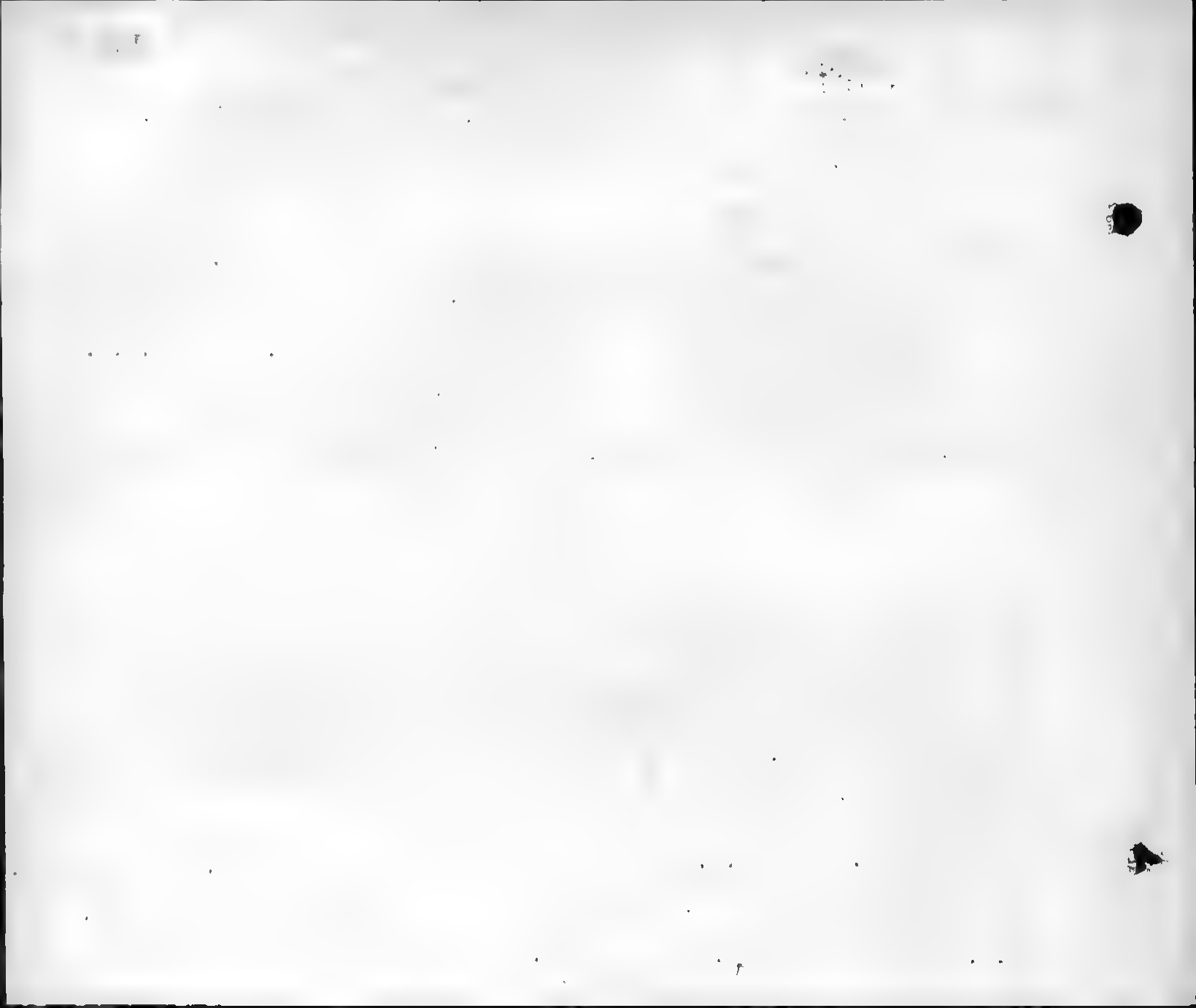
VR A15 (4)
15M 9/59

1
9960

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08914

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b Pikesville		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 1 605 Upland Road	
3 NAME OF DECEASED (Type or print) First Sara Middle Shreve Last Bishop		4 DATE OF DEATH Month Sept. Day 25 Year 19 60	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 18, 1878
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Madison Wallace		14. MOTHER'S MAIDEN NAME Sara Matilda Shreve	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-2448B	
17. INFORMANT Miss Matilda Bishop		Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) arterio-sclerotic & hypertensive DUE TO (c) arterio-sclerotic & hypertensive Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days. 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb 1930 to Sept 25 1960 , that (I) (we) last saw the deceased alive on Sept 25 1960 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Palmer F.C. Williams		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Palmer F.C. Williams		22d. ADDRESS 1725 Reisterstown Rd., Pikesville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-27-60	
23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR SEP 27 '60	
ADDRESS 4905 York Rd., Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9961

CERTIFICATE OF DEATH

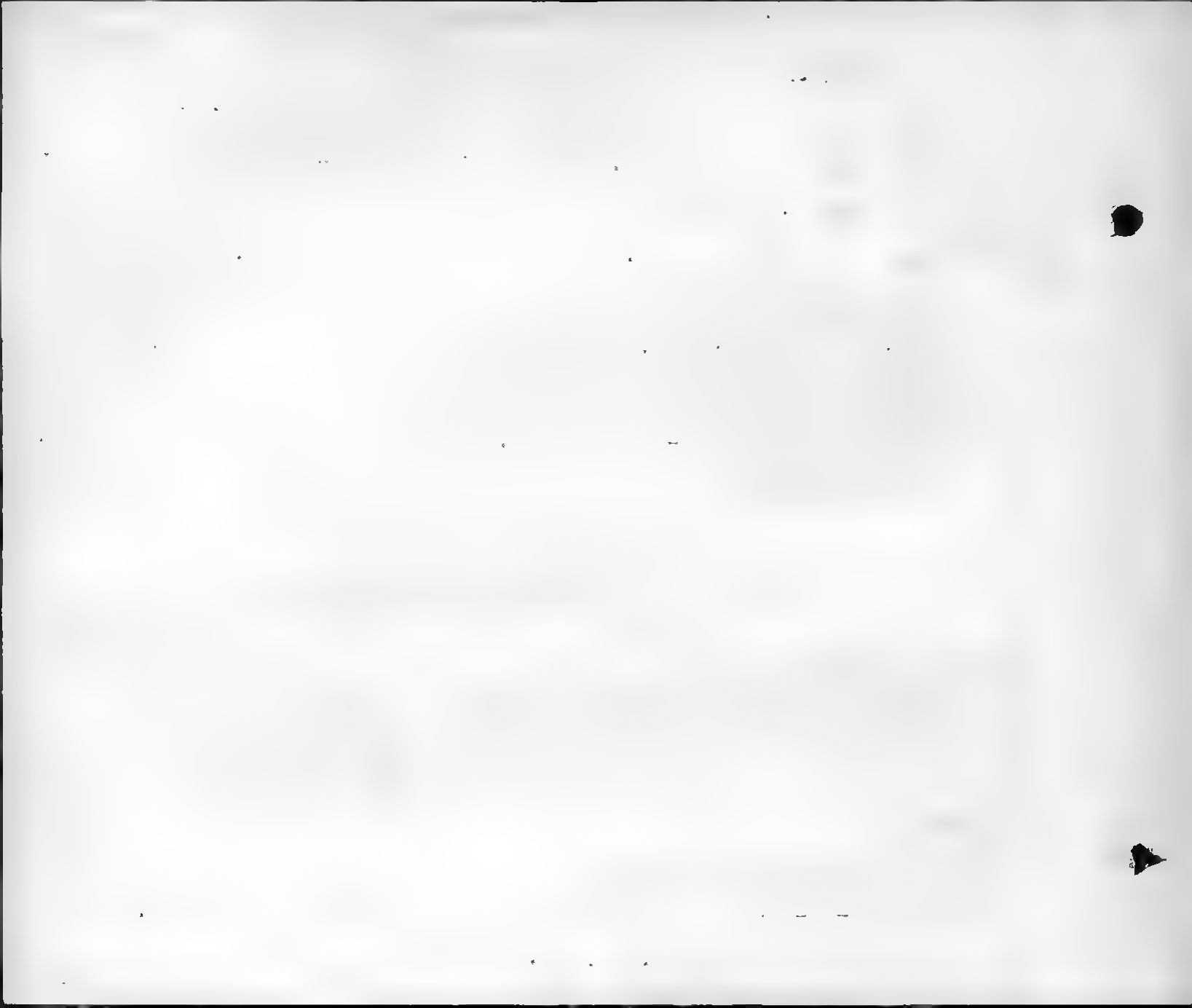
09916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b 1 Hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 914 D Street, Sparrows Point				e. STREET ADDRESS 17413 Blevins Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Franklin T. Blevins				4. DATE OF DEATH Month Day Year Sept. 7. 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1927		9. AGE (In years last birthday) yrs 33	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Pataps. Bk Rvr RR Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Blevins				14. MOTHER'S MAIDEN NAME Bessie Mae Ashley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes (If yes, give war or date of service) Army WW 11		16. SOCIAL SECURITY NO. 212-20-4249		17. INFORMANT Address Mrs. Regina Blevins 7413 Blevins Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 7, 1960 , to Sept 7, 1960 , that I last saw the deceased alive on Sept 7, 1960 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John V. Conway M.D.				ADDRESS (Street, city or town, state) 914 D St. Balt 19 DATE SIGNED 9-7-60			
PHYSICIAN'S NAME (Type) John V. Conway							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-1960		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md..	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md..				24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE William S. Kinn	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

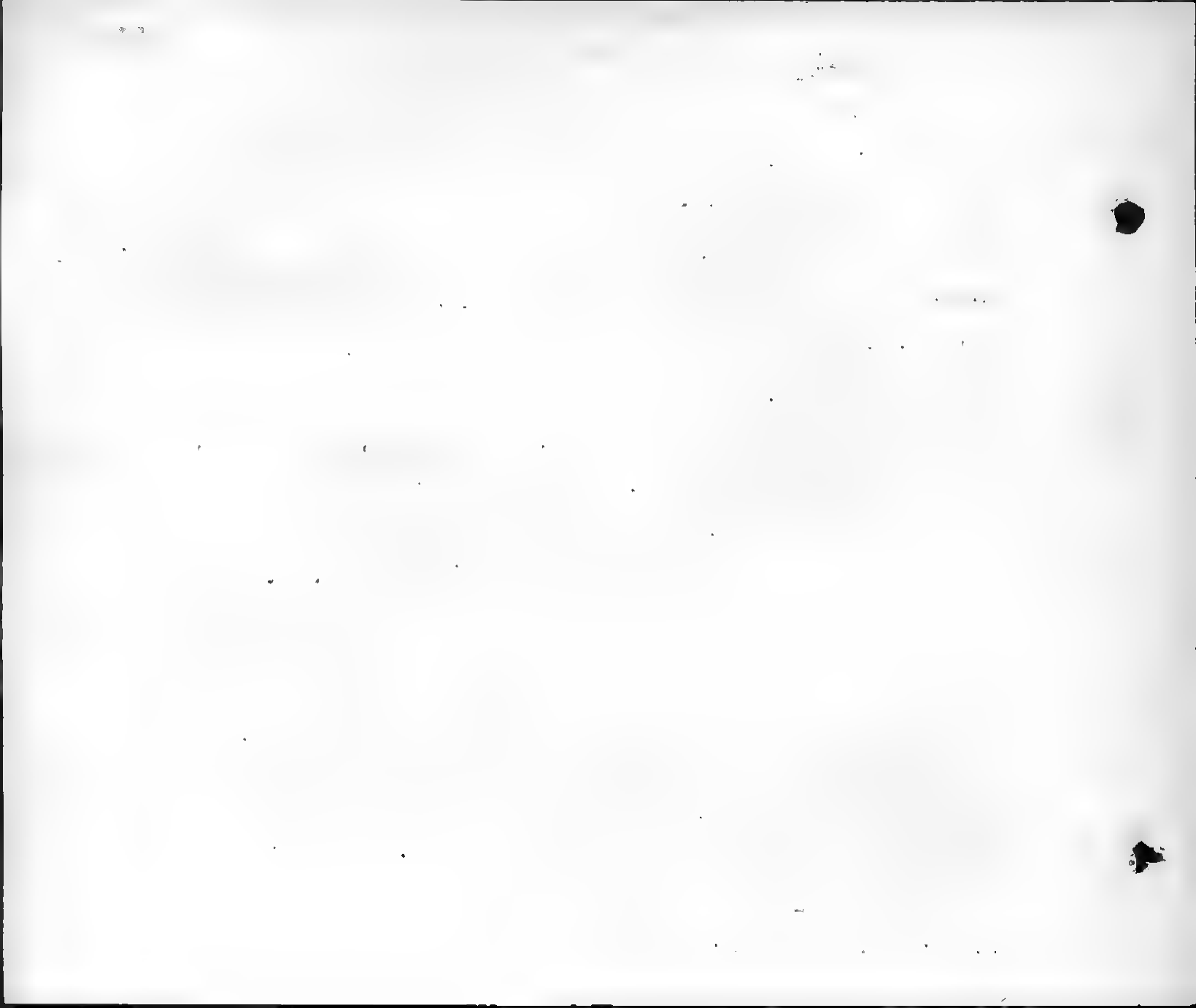
09917

9962

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY P. Ct	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b X Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home Smithwood & Summit Ave		e. STREET ADDRESS 6317 Banbury Street	
3. NAME OF DECEASED (Type or print) First Middle Last Charles BODE		4. DATE OF DEATH Month Day Year September 29 1960	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1871
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilhelm H. Bode		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address C. Allen Hechter, 6 Club Road, Baltimore 10	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary Edema DUE TO (b) Coronary Insuf. DUE TO (c) Arterioscl. cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 29, 1960 to Sept 29, 1960 , that I lost saw the deceased alive on Sept 29, 1960 , and that death occurred at 1:17 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Justus Rudika		ADDRESS (Street, city or town, state) 1709 Edmonson ave Catonsville	
PHYSICIAN'S NAME (Type) J. KUORKA		M.D. MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-1-60	22c. NAME OF CEMETERY OR CREMATORY Govans Presbyterian	22d. LOCATION (City, town, or county) (State) Baltimore 12, Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR OCT 3 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

09918

Reg. Dist. No.

9963

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5Yr 1mth 11dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harrison T. Bostwick				4. DATE OF DEATH Month September Day 10 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 28, 1906	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Harrison Bostwick				14. MOTHER'S MAIDEN NAME Louisa C. Wistland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) 1924		16. SOCIAL SECURITY NO 217-05-3405		17. INFORMANT Mrs. Ida Bauer, 2006 East Federal Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of larynx and tongue DUE TO (b) metastasis to the hypopharynx DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to syphilis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 3 , 19 59 , to Sept. 10 , 19 60 , that I last saw the deceased alive on Sept 10 , 19 60 , and that death occurred at 8 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED							
ACTUAL SIGNATURE Loretta Y. F. Hsu M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) LORETTA Y. F. HSU				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hsu	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9964

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge - Balto 12		c. LENGTH OF STAY IN lb 12		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge - Balto. 12		d. STREET ADDRESS 100 Dumbarton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JERE		First L.		Middle BOYD		Last		4. DATE OF DEATH Month Sept.		Day 11.		Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1874		9. AGE (In years last birthday) 86 yrs		10. UNDER 1 YEAR Months 5		11. UNDER 24 HRS Days 10		12. CITIZEN OF WHAT COUNTRY? 10 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Harbor Master		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? 10 yrs									
13. FATHER'S NAME Jere L. Boyd		14. MOTHER'S MAIDEN NAME Margaret Betz													
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Mrs. Margaret A. Boyd - 100 Dumbarton Rd.		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO (b) Arteriosclerosis DUE TO (c) 10 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none		20c. TIME OF INJURY Month, Day, Year Hour o m. none p. m. none		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none		(County) none		(State) none	
21. I certify that I attended the deceased from Aug 25 , 19 43 , to Sept 11 , 19 60 that I last saw the deceased alive on Jan 25 , 19 60 , and the death occurred at 9 AM , from the causes and on the date stated above. AS. Chalfant M.D. 6210 YORK ROAD ADDRESS (Street, city or town, state) DATE SIGNED Dr. A.S. CHALFANT BALTIMORE, 12. Md															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/60		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) Balto., Md.		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Sons - Balto		24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline											



TO DEPARTMENT OF HEALTH
 1
 FOR STATE
 HEALTH DEPT.
 (M)
 This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3
 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 9965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05921

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stearns, Md.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stearns, Md.</u>		
c. LENGTH OF STAY, in 1b			d. STREET ADDRESS <u>Stearns Road extended</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Valley Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIETTE-DORAN BURPERT</u>			4. DATE OF DEATH Month Day Year <u>9 24 1960</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-20-57</u>		
9. AGE (In years last birthday) <u>3</u> yrs.			10. AGE (If under 1 year) If UNDER 1 YEAR: Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			11b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		
11c. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>STUART BURPERT</u>			14. MOTHER'S MAIDEN NAME <u>Harriet Goldborough</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give year or dates of service)) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Stearns - Pikesville, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929. Drowning, (accidental)</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>None</u>					
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 15 min</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from swimming pool deck.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:45 am</u> <u>Sept 24</u> 19 <u>60</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stearns, Md.</u>					
20f. (City or town) (County) (State) <u>Stearns Baltimore Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) <u>9-24-60</u>					
DATE SIGNED					
ACTUAL SIGNATURE <u>E. D. Toppie</u> M.D.					
EXAMINER'S NAME (Type) <u>T. D. GATLES</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>9/27/60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>					
22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>					
23. FUNERAL DIRECTOR <u>Wm. J. Tietner & Sons - Balt. 17</u>					
ADDRESS					
24a. REC'D BY REGISTRAR DATE <u>SEP 27 '60</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9966

CERTIFICATE OF DEATH

11036

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> COUNTY <u>Anne Arundel Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion C.</u> Middle <u>Burge</u> Last <u></u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1893</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sam. Cruse</u>		14. MOTHER'S MAIDEN NAME <u></u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Spring Grove Hosp. records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction, anterior-extensive</u> 7-20-0 DUE TO <u>Arterio-sclerotic heart disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8-17-1960</u> to <u>9-24-1960</u> , that (I) (we) last saw the deceased alive on <u>9-24-1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Stella Wachslar</u> M.D.		22b. DATE SIGNED <u>9-27-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Blundell E. 28</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



9967

CERTIFICATE OF DEATH

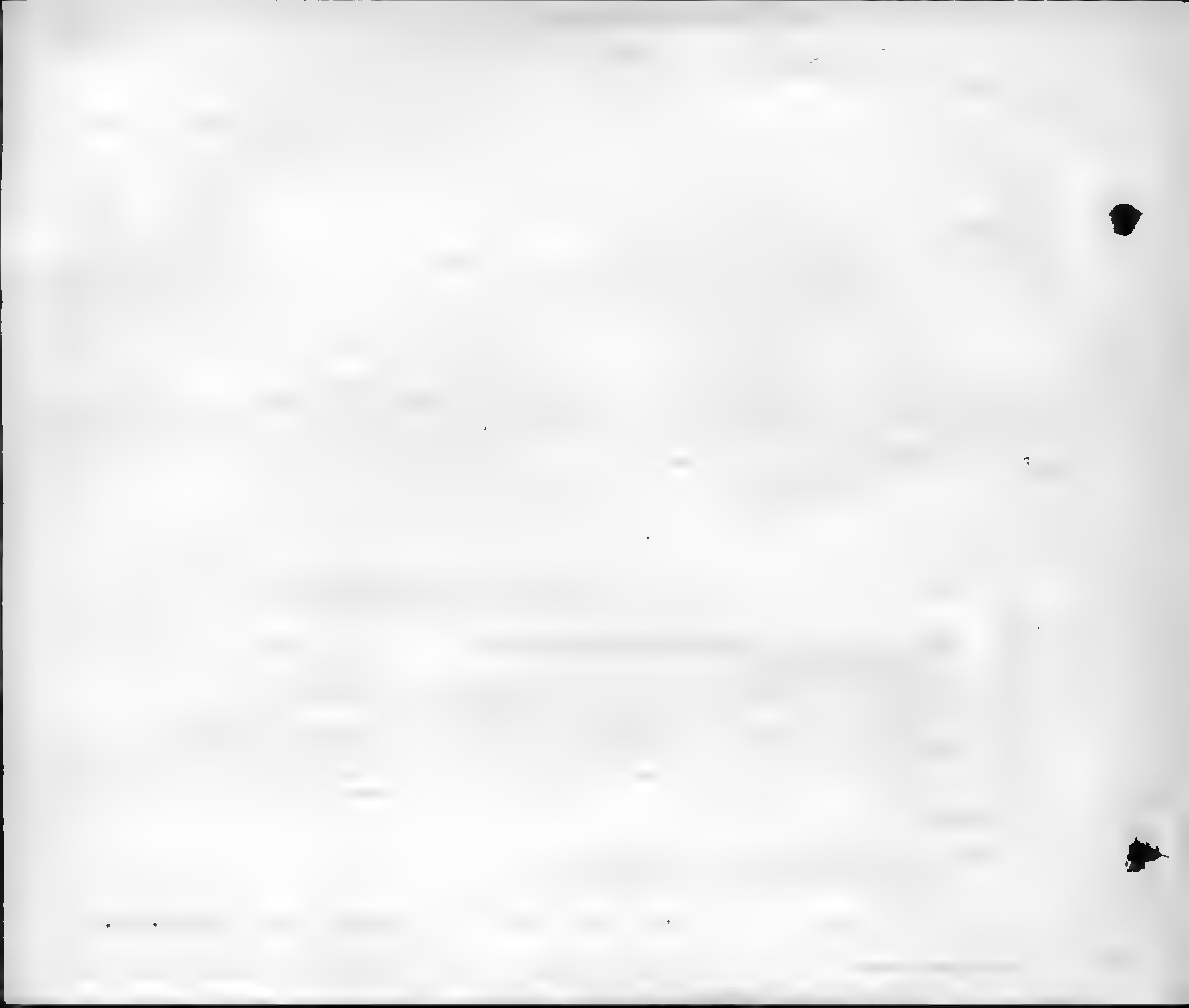
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. LENGTH OF STAY IN TB <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sweet Air Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA VIRGINIA BURK</u>		4. DATE OF DEATH Month Day Year <u>September 25 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2, 1887</u>
9. AGE (In years last birthday) <u>73 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SPINSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY, USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN CONRAD BURK</u>		14. MOTHER'S MAIDEN NAME <u>LYNDE CHARLOTTE HOMAN</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-34-1179</u>	
17. INFORMANT <u>MRS EAHN MOSNER PRICE</u>		Address <u>21500 Gardens SMITHS RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4a. 1.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary Insufficiency</u> (b) <u>Coronary Insufficiency</u> (c) <u>Coronary Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>Two hours</u> <u>Two months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>25 Sept 60</u> to <u>25 Sept 60</u> , that I last saw the deceased alive on <u>25 Sept 60</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		DATE SIGNED <u>7:55 PM 1960</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS <u>Sweet Air Rd. Balto. Co. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-28-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u> ADDRESS <u>7401 Delmar Rd.</u>		24a. REC'D BY REGISTRAR <u>SEP 27 60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kees</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

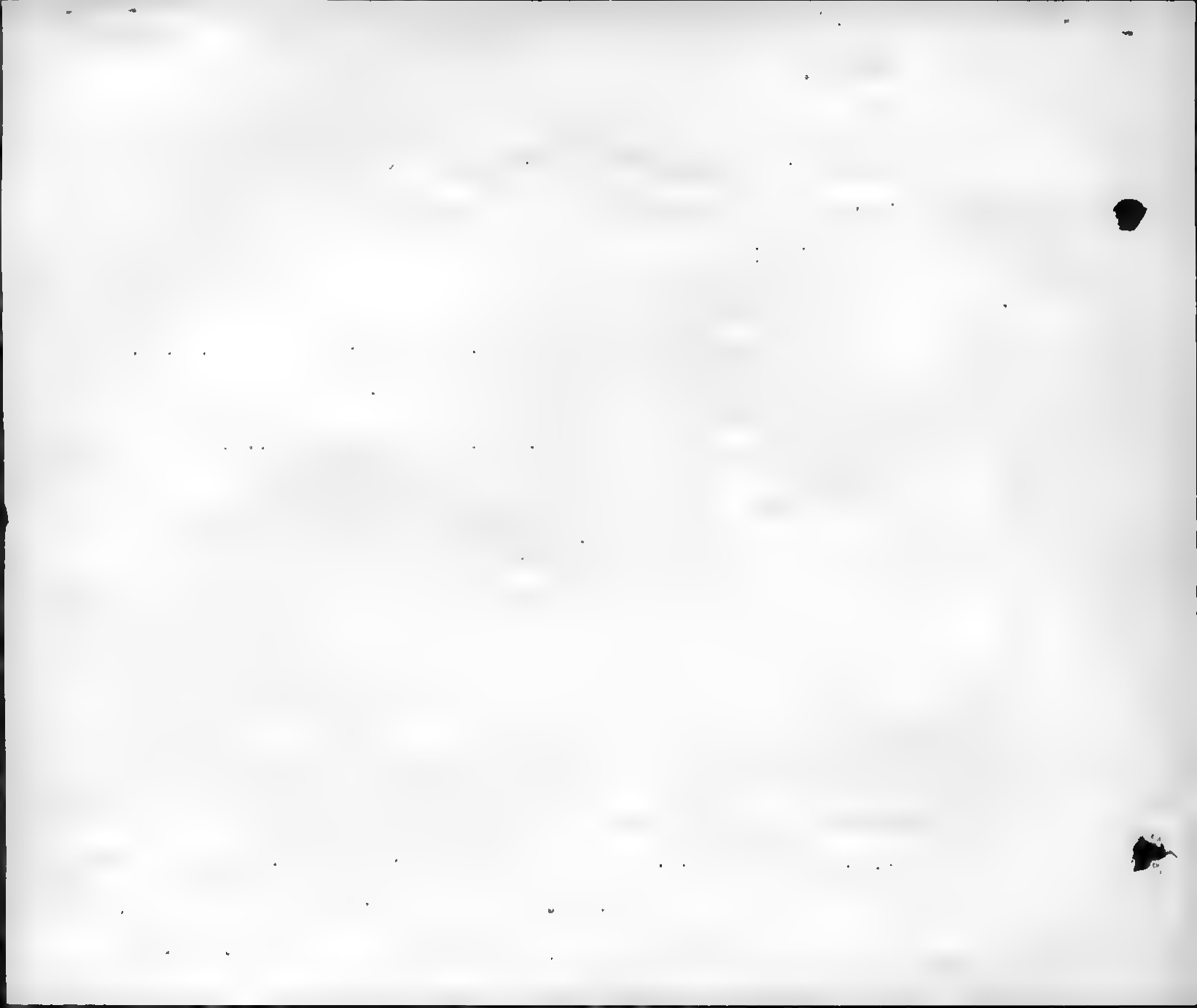
(I)

9968

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09923

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN lb 13 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 1210 Canal Court, Apartment B.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle -- Last BUTLER				4. DATE OF DEATH Month September Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1896	9. AGE (n years last birthday) yrs 64	IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
11. BIRTHPLACE (State or foreign country) Warrenton, Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Jacob Butler	
14. MOTHER'S MAIDEN NAME Henrietta Johnson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes				
16. SOCIAL SECURITY NO Clin. Rec. VAH, Balto. 18, Md. FT. HOWARD DIVISION			17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FT. HOWARD DIVISION				
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING CHRONIC PEPTIC ULCER OF STOMACH WITH MASSIVE HEMORRHAGE IN THE GASTRO-INTESTINAL TRACT Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MARKED CEREBRAL ARTERIOSCLEROSIS WITH OLD INFARCT OF THE RIGHT TEMPORAL OCCIPITAL LOBES (c) MARKED CEREBRAL ARTERIOSCLEROSIS WITH OLD INFARCT OF THE RIGHT TEMPORAL OCCIPITAL LOBES							INTERVAL BETWEEN ONSET AND DEATH 1 DAY 4 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from Sept. 6, 1960 to Sept. 19, 1960 , that he (we) last saw the deceased alive on 9/19/60 19 and that death occurred at 11:45A M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson M.D.				22b. DATE SIGNED 9/20/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/22/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. 17	
25a. REC'D BY REGISTRAR SEP 22 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



CERTIFICATE OF DEATH

Reg. Dist. No.

09924

9969

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CENTER CIRCLE TOWSON ESTATES</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret - M - Campbell</u>				4. DATE OF DEATH Month Day Year <u>Sept 18 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-9-1873</u>	9. AGE (In years lost birthday) yrs <u>86</u>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE-MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE-A. CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BARKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>KATHERINE C. BOUNTREE 716 VALENCIA AVE CORAL GABLES, FLA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>coronary thrombosis at infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO <u>hypertension</u> (c) <u>interval between onset and death</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>BALTIMORE</u>	(County) <u>MARYLAND</u>	(State) <u>MARYLAND</u>		
21. I certify that I attended the deceased from <u>12:00</u> to <u>1:30</u> PM, 19 <u>60</u> , that I last saw the deceased alive on <u>15 Aug</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>11403 Fiddlers Lane, Baltimore, Md.</u> DATE SIGNED <u>SEP 21 '60</u>							
ACTUAL SIGNATURE <u>W M Cook</u>		PHYSICIAN'S NAME (Type) <u>W M Cook</u>					
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE-MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W M Cook-TOWSON, INC</u>		ADDRESS <u>TOWSON 4-MD</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

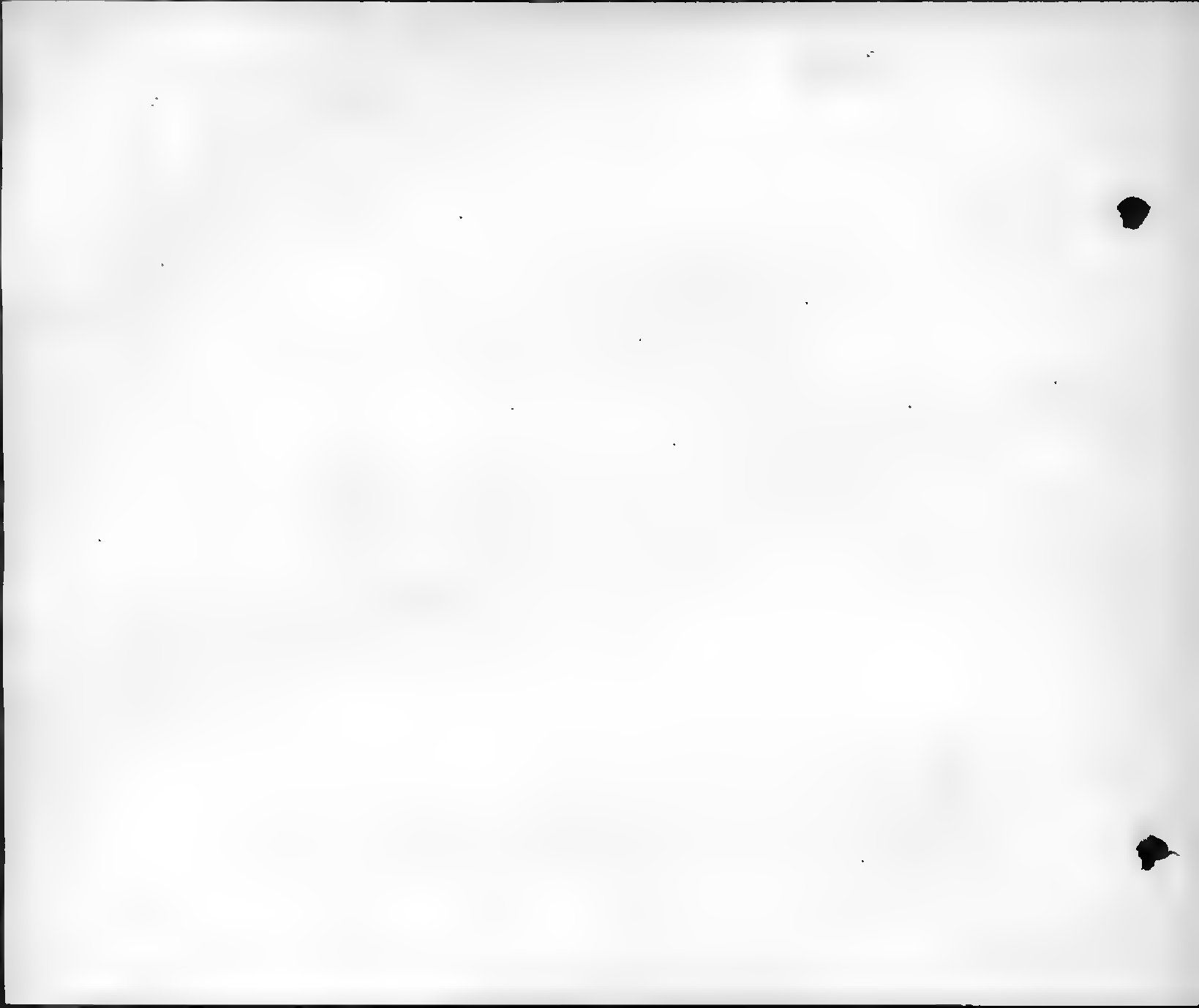
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

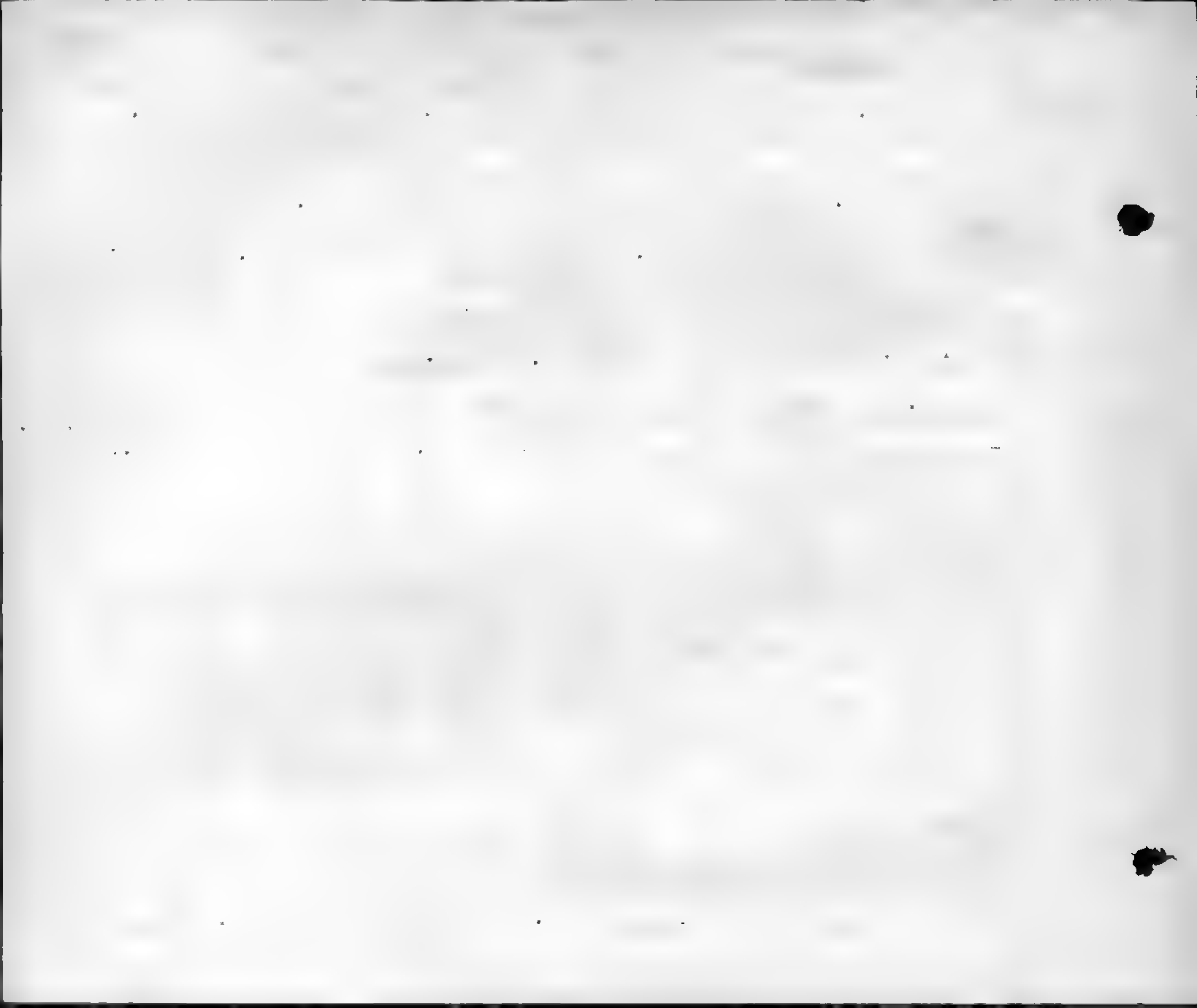
09925

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1824 Park Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle H. Last CAROTHERS				4. DATE OF DEATH Month Sept. Day 27, Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1875		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acct. Rtd.		10b. KIND OF BUSINESS OR INDUSTRY Singer Sewing Machine Co.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME James E. Carothers				14. MOTHER'S MAIDEN NAME Clara Eisenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Sarah C. Rhode - 13 Overbrook Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Hypertension of Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo S. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GEORGE S. KIEFFER M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/30/60		22c. NAME OF CEMETERY OR CREMATORY Greenhill Cem.		22d. LOCATION (City, town, or county) (State) Danville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Siskens & Sons				ADDRESS Baltimore		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
						24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse via this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



1
TO HOSPITAL: FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

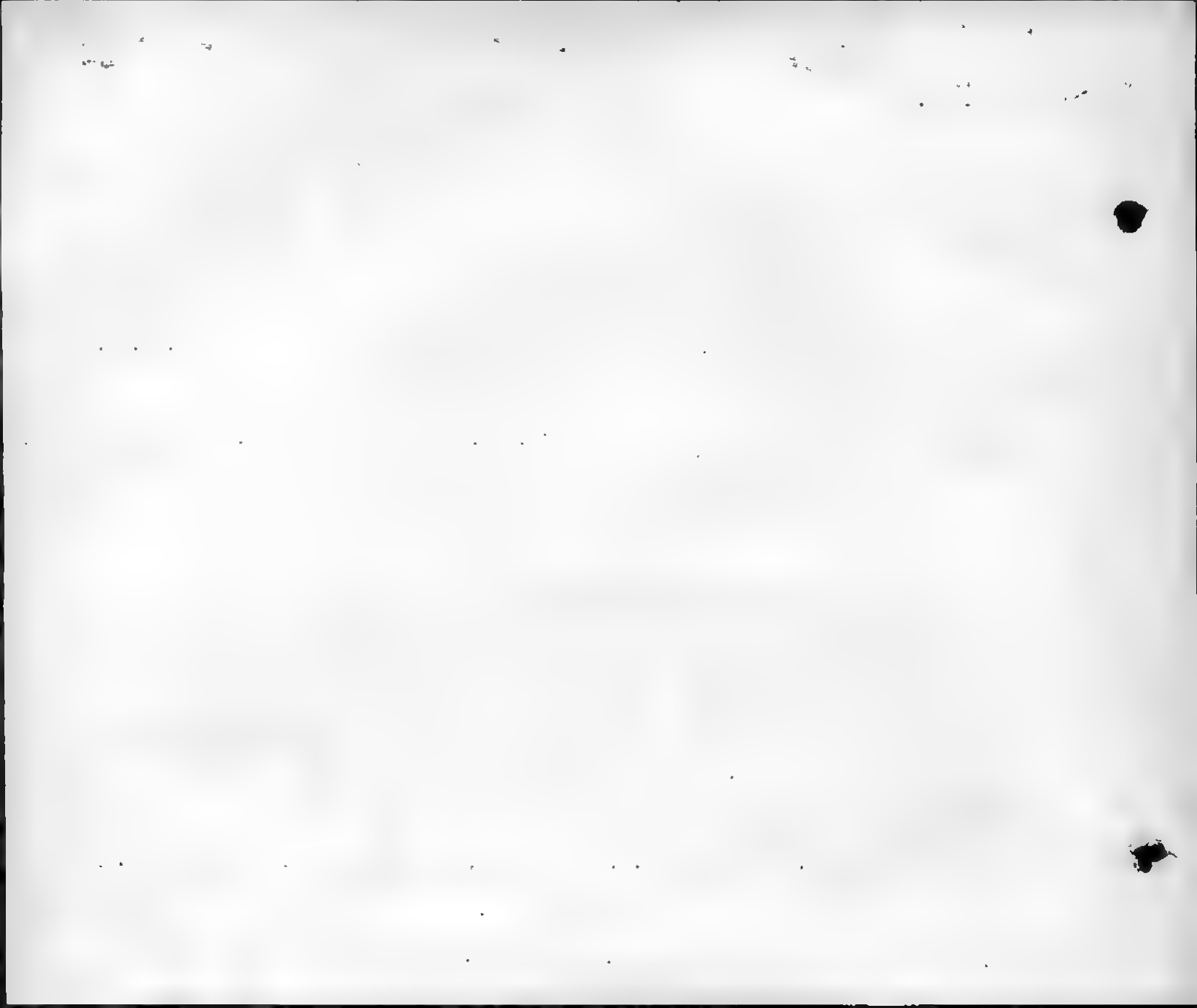
VR A15 (4)
15M 9/59

9970

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PHILLIP Middle --- Last CARROLL				4. DATE OF DEATH Month September Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1894	
9. AGE (In years as birthday) yrs 66		10. IF UNDER 1 YEAR: Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Carroll				14. MOTHER'S MAIDEN NAME Ella MN: Henessey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO.			
17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO CARCINOMA OF SOFT PALATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 4 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore (County) Maryland (State) Maryland				20g. (City or town) Baltimore (County) Maryland (State) Maryland			
21. I certify that (X) (this hospital) attended the deceased from August 2, 1960 to September 1, 1960 , that (X) (we) last saw the deceased alive on Sept. 1, 1960 , and that death occurred at p. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 9/2/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National.	
23d. LOCATION (City, town or county) Baltimore (State) Maryland				23e. LOCATION (City, town or county) Baltimore (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balt 14, Md.				25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
9971
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09927

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u>	
c. LENGTH OF STAY IN 1b <u>10 years</u>		d. STREET ADDRESS <u>St Paul ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Paul ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GRACE Josephine CAVEY</u> First Middle Last		4. DATE OF DEATH <u>Sept. 18</u> 19 <u>60</u> Month Day Year	
5. SEX <u>A.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1869</u>
9. AGE (In years last birthday) <u>91</u> yrs		10. IF UNDER 1 YEAR: Months Days	
11. IF UNDER 72 HRS: Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry A. Bodke</u>		14. MOTHER'S MAIDEN NAME <u>? Gallagher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Mr. Francis Miller - Granite, md.</u>		Address <u>Granite, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>			
17a. DUE TO <u>Carcinoma of Breast</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>55</u> , to <u>Sept. 18</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept. 18</u> 19 <u>60</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. E. Martin</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		22d. ADDRESS <u>RANDALLSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Alphonsus</u>		23d. LOCATION (City, town, or county) (State) <u>Woodstock, Balt Co., md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> Address <u>Sylkesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>			

MEDICAL CERTIFICATION



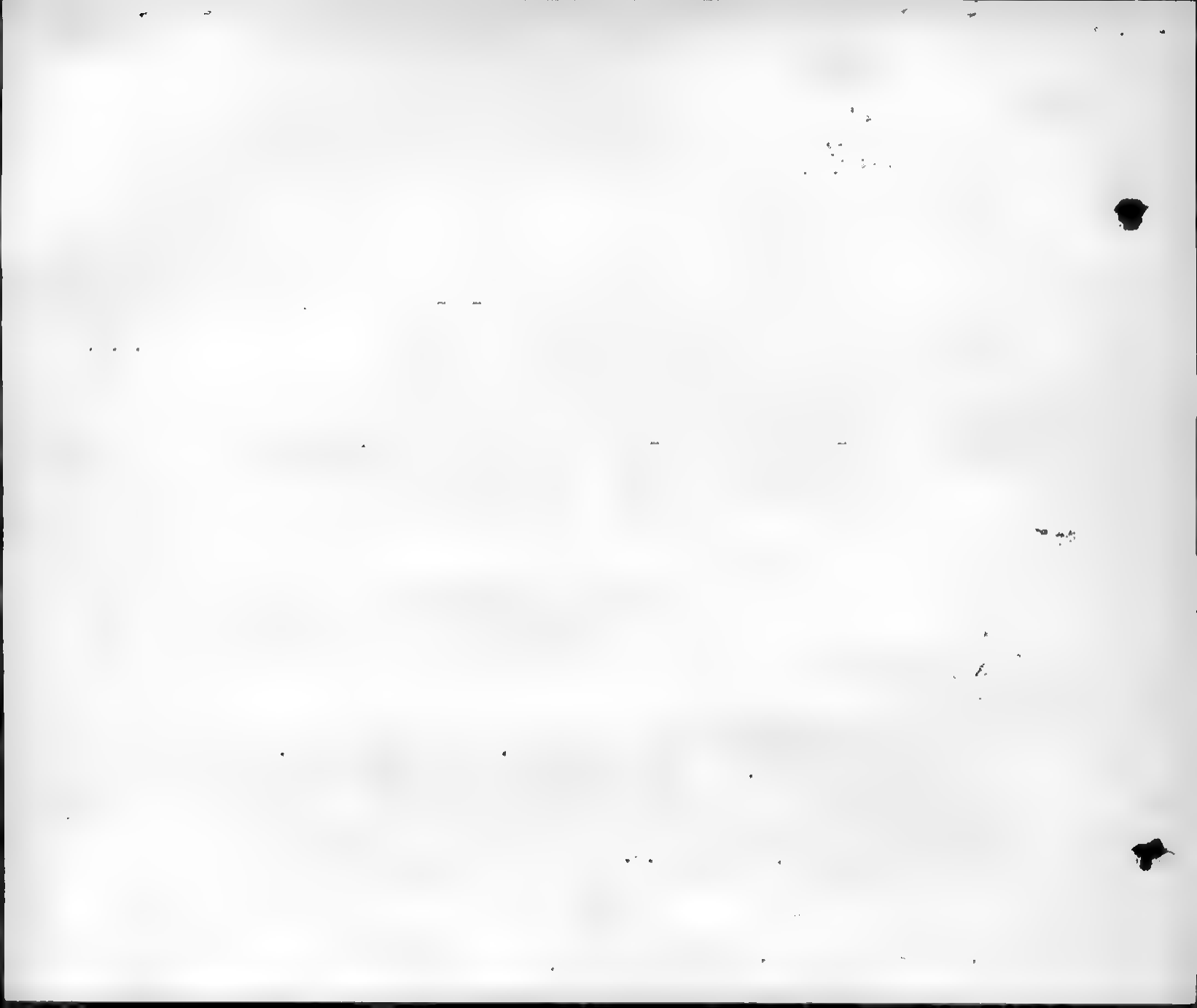
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9972

09928

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 3 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1607 STONEY LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H Last CHAMBERS				4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-26-97	
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		IF UNDER 24 HRS Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10b. KIND OF BUSINESS OR INDUSTRY TAXI CAB COMPANY			11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM CHAMBERS				14. MOTHER'S MAIDEN NAME LILLIAN DEYHOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 217-20-7798		17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) EDEMA OF LUNGS (c) EMPHYSEMA OF LUNGS							INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1-1/2 DAYS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Sept. 22, 1960 to Sept. 25, 1960 , that he (we) last saw the deceased alive and Sept. 25, 1960 and that death occurred at 12:15 from the causes and on the date stated above.							
22a. SIGNATURE <i>Jerome D. Gorman</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-25-60	
22c. PHYSICIAN'S NAME (Type) JEROME D. GORMAN, M.D.				22d. ADDRESS VAH Baltimore Md Ft Howard Div			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR 6009 Harford Rd Baltimore 14, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

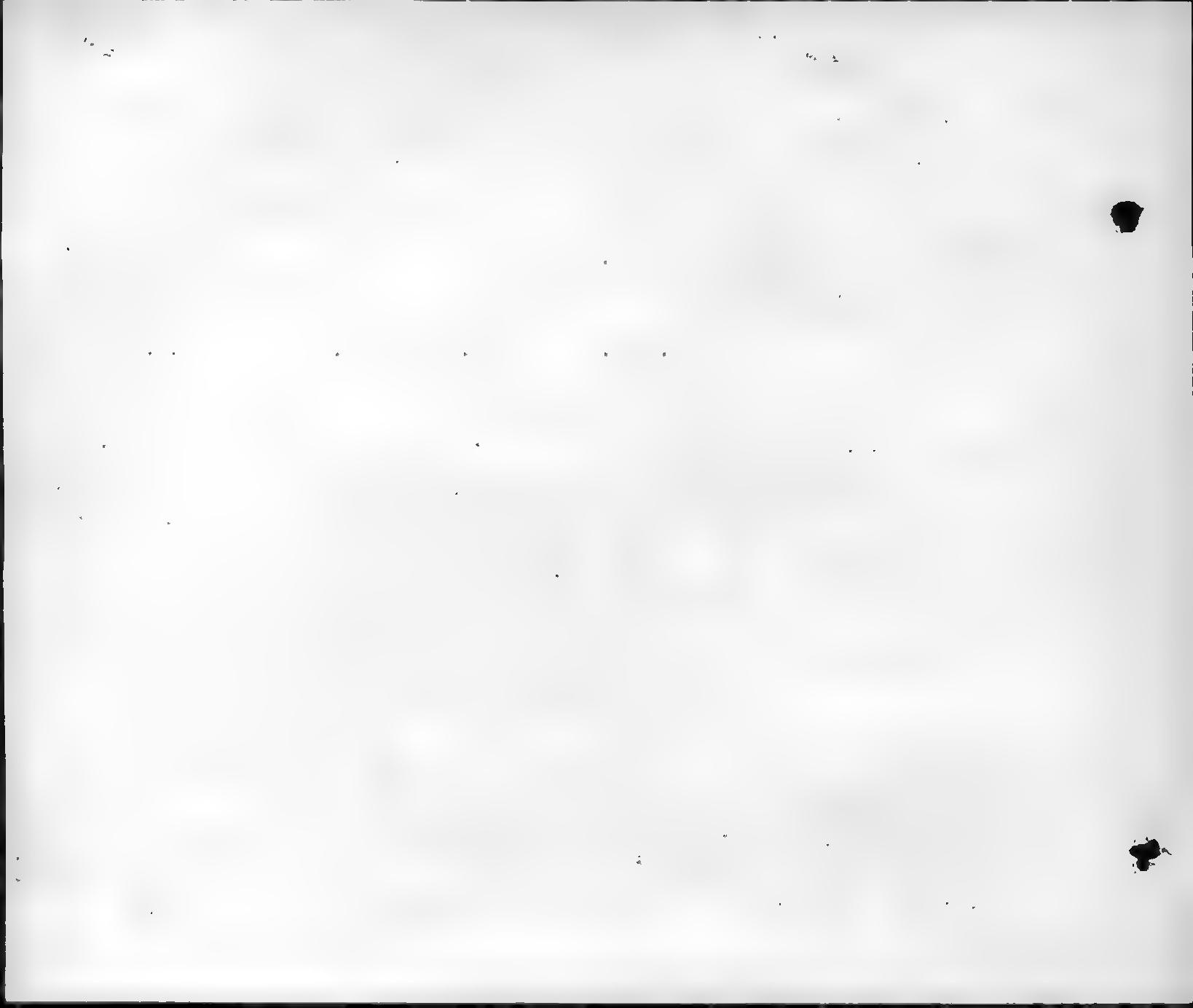
9973

Item 1 - Film 2-1 9-26-60 et

CERTIFICATE OF DEATH

09929

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At his own home."		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 220 Garden Ridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Harry Middle H. Last Cheatham		4. DATE OF DEATH Month 9 Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9--23-1896
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 14 Min 14	11. IF UNDER 24 HRS Hours 14 Min 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Mfr. Agt.	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Cheatham		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 8609624	
17. INFORMANT Rella M. Cheatham		Address 220 Garden Ridge Rd. 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bleeding Duodenal Ulcer DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Pancreas - Liver Metastases 4 yrs (c) Diabetes Mellitus 3 yrs. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-29-1956 to 9-14-1960 that (I) (we) last saw the deceased alive on 9-14-1960 and that death occurred at 8:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Siver		22b. DATE SIGNED 9-16-60	
22c. PHYSICIAN'S NAME (Type) R. H. Siver		22d. ADDRESS 3105 N. Charles St. Balto. 18, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-1960	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Maury Abbott & Son		25a. REC'D BY REGISTRAR SEP 20 '60	
ADDRESS 28		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974

CERTIFICATE OF DEATH

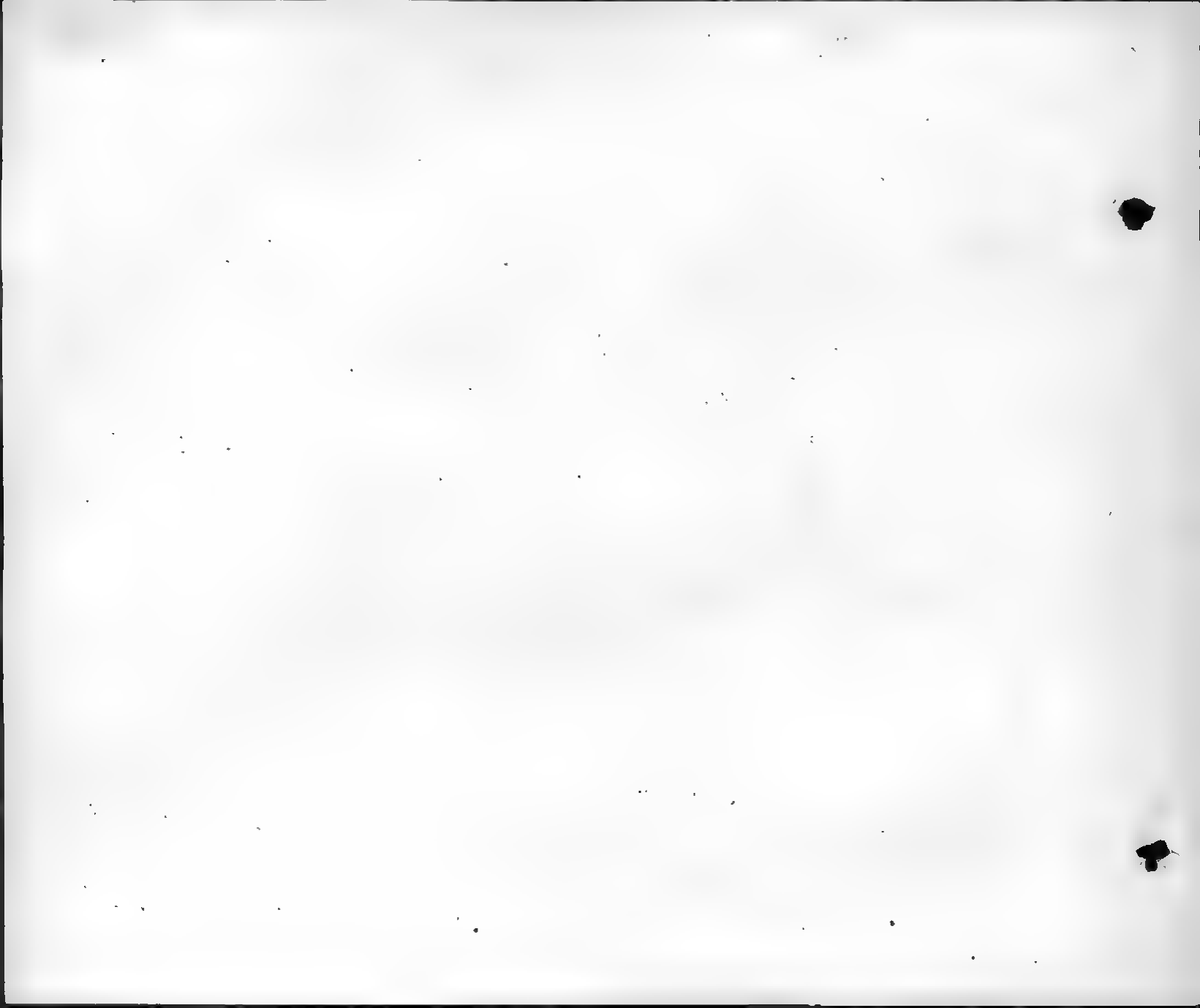
09930

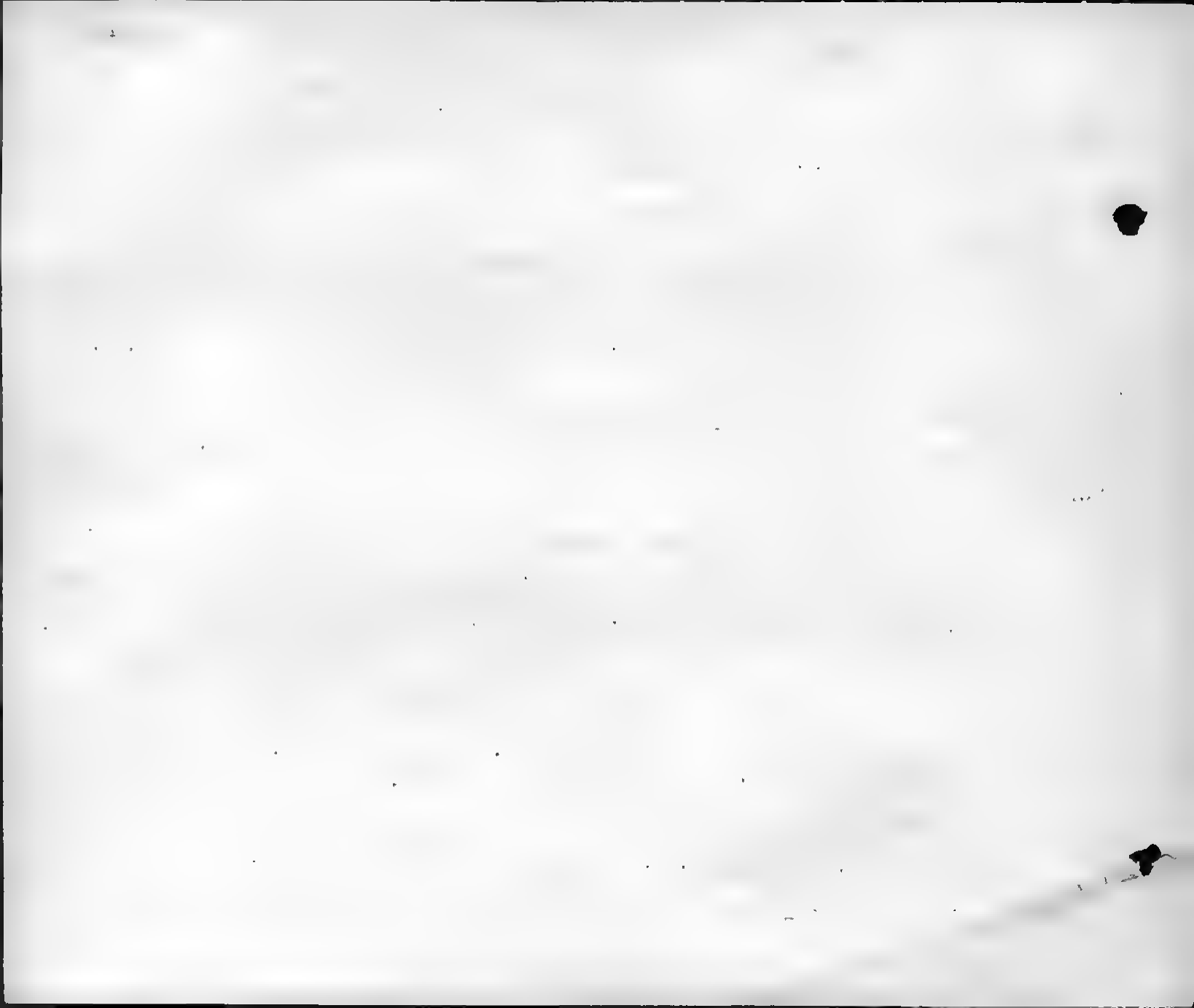
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockeyville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockeyville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ROSE - V - CHILCOAT</u>		4. DATE OF DEATH <u>Sept 16</u> 19 <u>60</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25-1881</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles T. Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Julian Johnson - Dover Rd - Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153</u> DUE TO <u>Chronic - cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat. white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>Sept 16 1960</u> that I last saw the deceased alive on <u>Sept 15 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Wickham</u> MD 11904 <u>Rockeyville Rd, Sept 15 1960</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) _____		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Ripton</u>		24a. REC'D BY REGISTRAR <u>SEP 21 1960</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

M

I





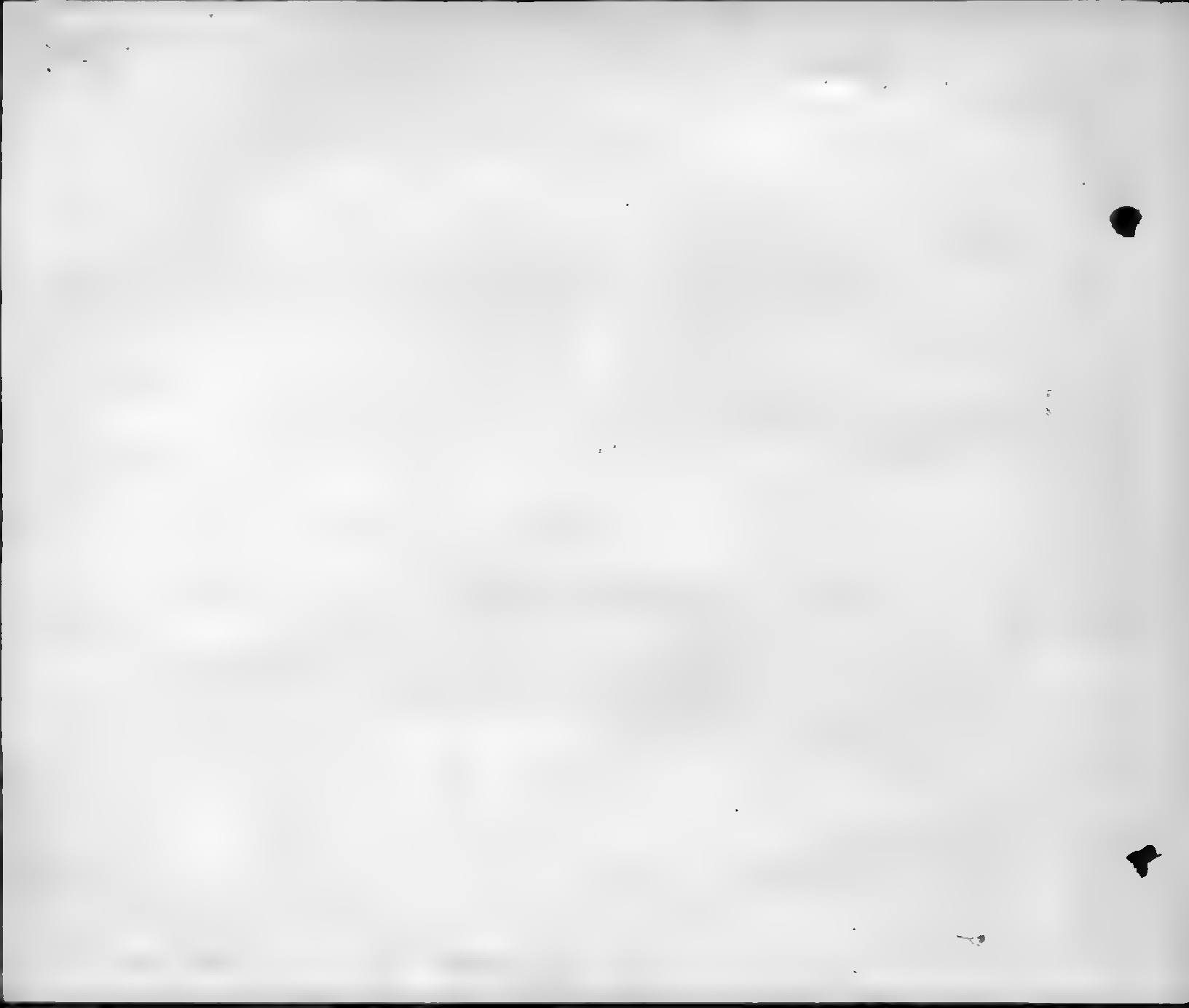
TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE HEALTH DEPT. M

9976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09931

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Int. Wilson St. Hosp.</u>		d. STREET ADDRESS <u>520 N. 1st St.</u>	
3. NAME OF DECEASED (Type or print) <u>LINDSEY C. COBBLER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M.</u>		6. DATE OF DEATH <u>9-11-1960</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>with Cobblers</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cobbler</u>		14. MOTHER'S MAIDEN NAME <u>Alice?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>2059254042008</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of heart</u> DUE TO (b) <u>Partial embolism in</u> DUE TO (c) <u>Right ventricular infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a, b, c):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day Year <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Sept. 15, 1960</u>		22b. DATE THEREOF <u>Sept. 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Peters Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>Frank J. Russell</u>		24. REC'D BY REGISTRAR <u>SEP 19 '60</u>	
ADDRESS <u>9-11-60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MD.		b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2117 E. Wilson		c. LENGTH OF STAY IN 1b 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake		d. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2117 E. Wilson				d. STREET ADDRESS 2117 E. Wilson			
3. NAME OF DECEASED (Type or print) First Middle Last JESSE CLARK COLLINS				4. DATE OF DEATH Month Day Year Sept 15 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-1893	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY VA. Schools		11. BIRTHPLACE (State or foreign country) Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George M. Collins				14. MOTHER'S MAIDEN NAME Elizabeth Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-36-7094		17. INFORMANT Dr. William H. H. H. H.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 77 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1. Myocardial infarction 2. Atherosclerosis 3. Hypertension DUE TO Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2. Diabetes - arteriosclerosis of heart		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. 4:30 a. m. Sept 15 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chesapeake Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Taylor				DATE SIGNED 5. 15. 60			
EXAMINER'S NAME (Type) D. D. CAPILL				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60		22c. NAME OF CEMETERY OR CREMATORY Shady Grove		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. H. H.				24a. REC'D BY REGISTRAR SEP 19 1960		24b. REGISTRAR'S SIGNATURE Charles E. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/59

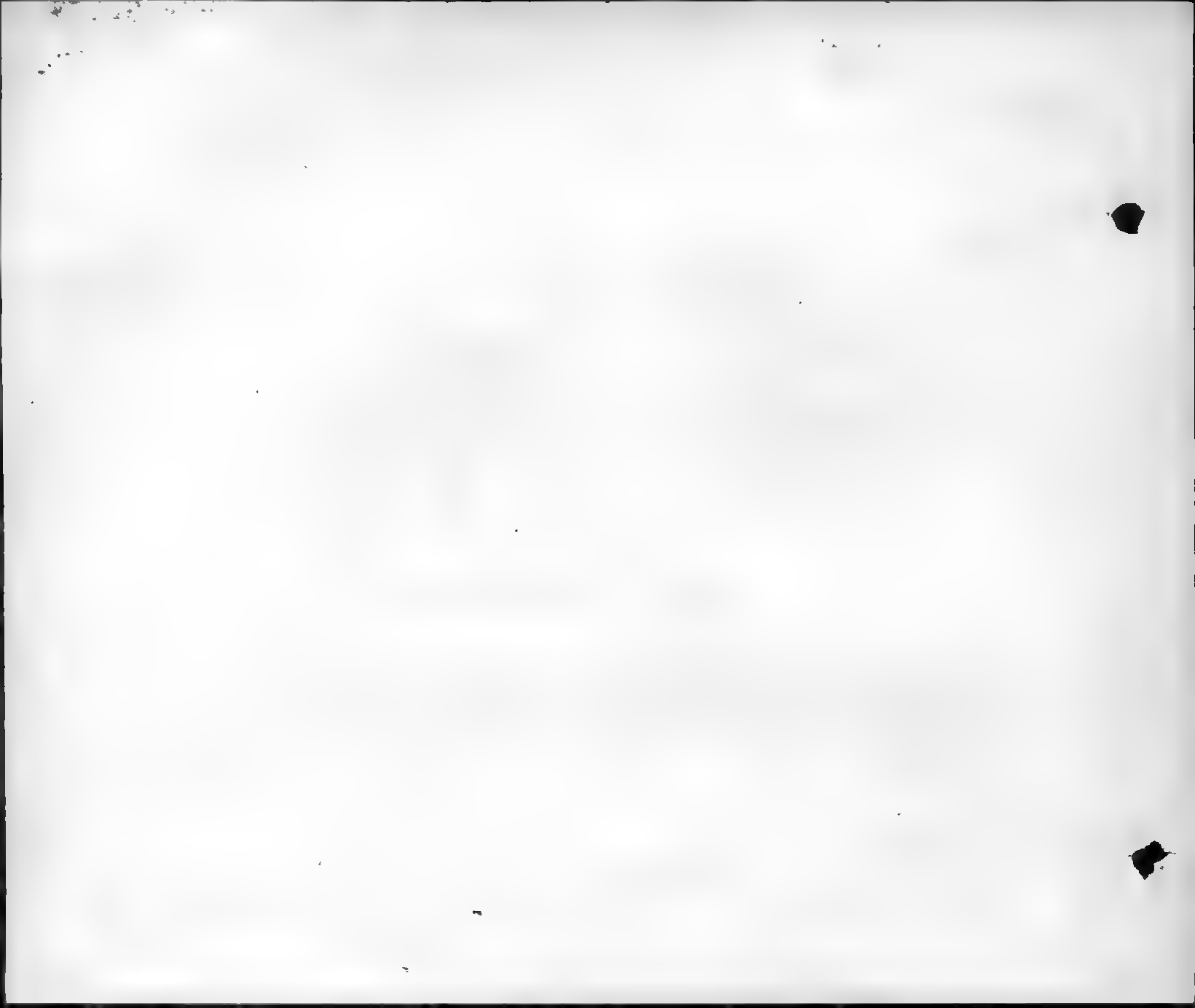
1

9978

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09933

1. PLACE OF DEATH (Where deceased lived If institution Residence before admission) a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills Md</u>				c. LENGTH OF STAY IN 1b <u>Baltimore, 17, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>1708 North Eutaw Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Kerwin</u> Middle <u>Conn</u> Last <u>Conn</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1960</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>Neuro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-60</u>	9. AGE (In years last birthday) yrs <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Lawson Conn</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Elizabeth Douglas Conn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rosewood Records</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive hydrocephalus</u> DUE TO <u>complicated by aspiration of stomach content</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-16</u> 19 <u>60</u> to <u>9-3</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9-3</u> 19 <u>60</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. W. Kiehl</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9-4-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>				22d. ADDRESS <u>4307 Mainfield Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 7-1960</u>		<u>Rosewood Cemetery</u>		<u>Owings Mills Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer Sons Rustatours</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



may be signed by the attending physician and completely filled by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9979

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09934

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore Co.</u>	
c. LENGTH OF STAY IN 1b <u>6 yr. 7 mo 8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>1111 N. ...</u>	
3. NAME OF DECEASED (Type or print) LAST <u>Metz</u> Middle <u>Elizabeth</u> FIRST <u>Caro</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Metz</u>		14. MOTHER'S MAIDEN NAME <u>Jane Ellen Grimm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Mrs. C. 7897</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease due to Arterio Sclerotic</u> DUE TO <u>Arterio Sclerotic</u> (b) <u>Arterio Sclerotic</u> DUE TO <u>Arterio Sclerotic</u> (c) <u>Arterio Sclerotic</u> PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>60</u> to <u>9-30-60</u> that (I) (we) lost saw the deceased alive on <u>9-2-60</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Gertrude J. Fleischmann</u> M.D.		22b. DATE SIGNED <u>9.3.60</u>	
22c. PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>		22d. ADDRESS <u>Spring Grove St Hospital</u>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Evangelical Church</u>	23d. LOCATION (City, town, or county) (State) <u>Locust Grove Wash. Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Best Haven Funeral Chapel Hagerstown</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Wm. C. Horst</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

11

2000

1
FOR STATE
HEALTH DEPT.

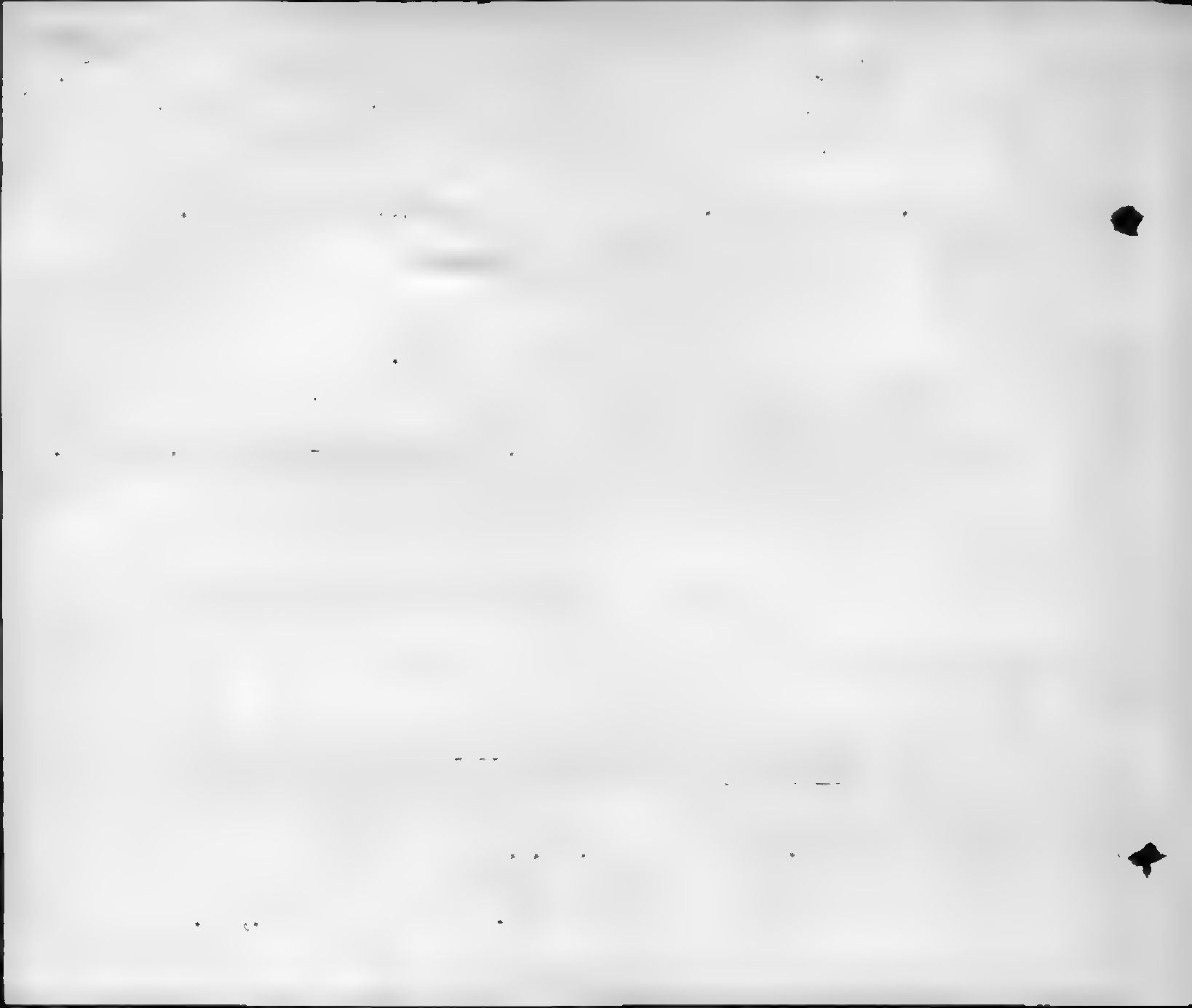
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Deputy Medical Examiner. Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Nov

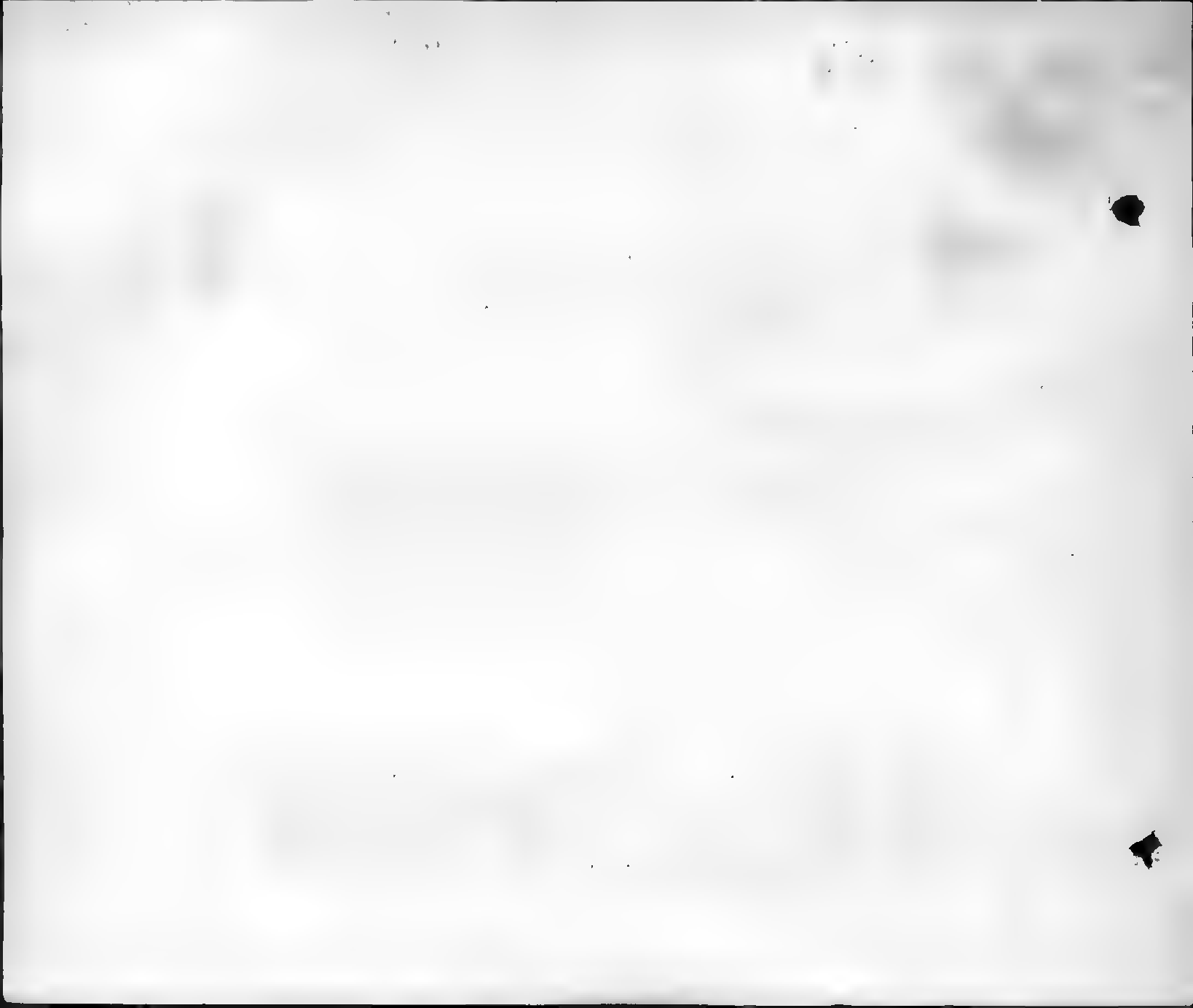
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9980 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09935

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 372, Walnut Grove Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Box 372, Walnut Grove Rd. 21 d. STREET ADDRESS Box 372, Walnut Grove Rd. 21			
3. NAME OF DECEASED (Type or print) First JOHN Middle WAYNE also Edwards Last CORNETT				4. DATE OF DEATH Month September Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		9. AGE (In years last birthday) yrs. 1 3 IF UNDER 1 YEAR: Months 1 Days 3 IF UNDER 24 HRS.: Hours 1 Min. 3		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown Edwards				14. MOTHER'S MAIDEN NAME Betty Sue Cornett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Dollie Cornett - Box 372 Rt. 1, Balto. 21				Address Box 372 Rt. 1, Balto. 21			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .							
SIGNATURE W. Bradley King, Jr., M.D.				DATE SIGNED 9/28/60			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/30/60			
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.				22d. LOCATION (City, town, or country) Balto. Md.			
23. FUNERAL DIRECTOR Wm. J. Dickman-Hous-Boat				24a. REC'D BY REGISTRAR Oct 3 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus				24c. REGISTRAR'S NAME Arthur L. Kraus			



09936

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24hr4mth14days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Sparks, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Naoma Middle M. Last Costa		4. DATE OF DEATH Month September Day 1 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1904
9. AGE (In years last birthday) 55 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Wertz		14. MOTHER'S MAIDEN NAME Clara May Knapp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown, If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive cardiovascular disease DUE TO (c) Infarctive myocardial fibrosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhagic colitis - undetermined etiology		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Sparks, Maryland		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1960 to Sept. 1, 1960 , that (I) (we) last saw the deceased alive on Sept. 1, 1960 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 9-1-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 4, 1960	23c. NAME OF CEMETERY OR CREMATORY New Freedom Cem.	23d. LOCATION (City, town, or county) (State) New Freedom, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Heston		25a. REC'D BY REGISTRAR SEP 6 1960	
ADDRESS New Freedom, Pa.		25b. REGISTRAR'S SIGNATURE Charles S. Heston	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

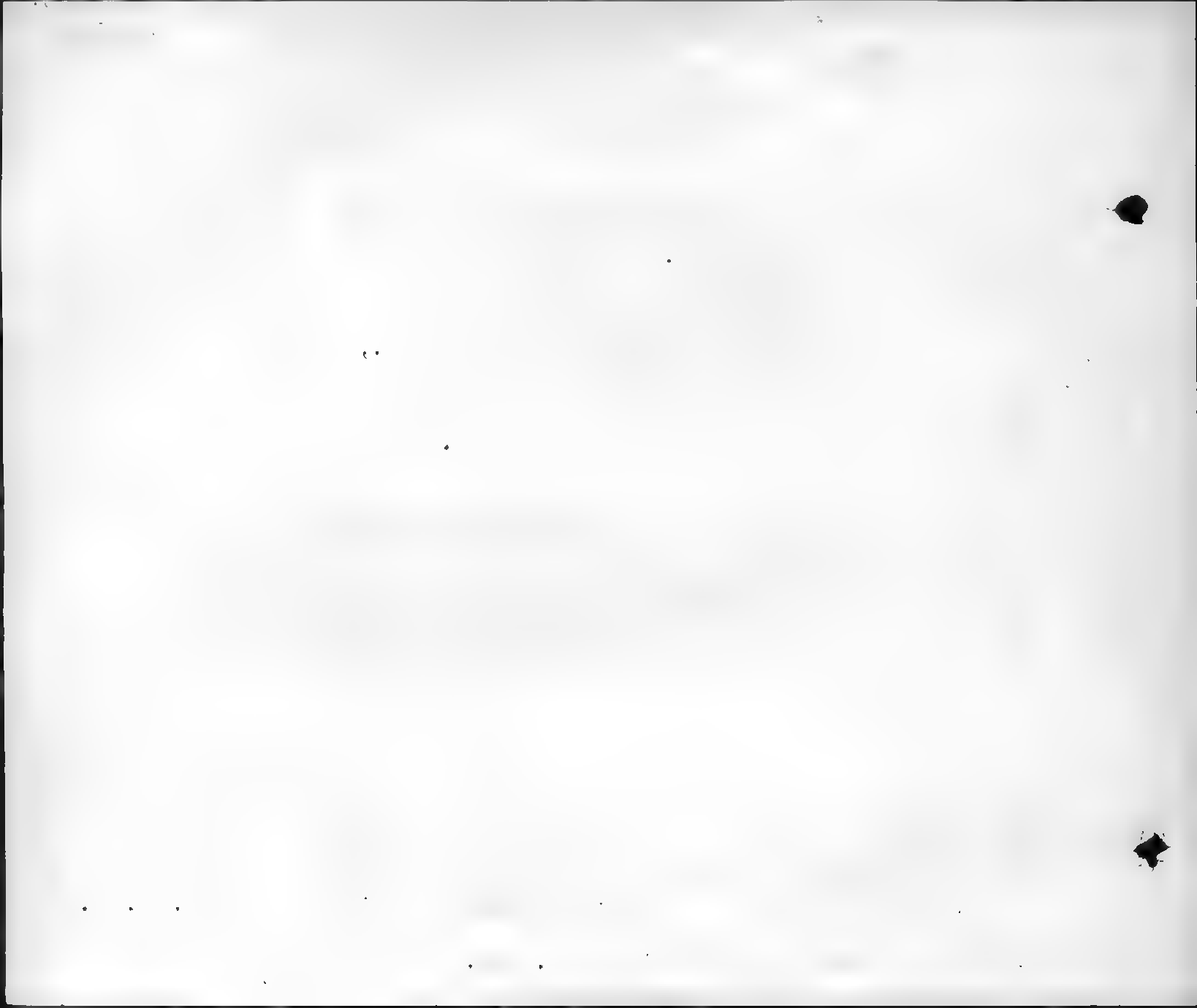
9982

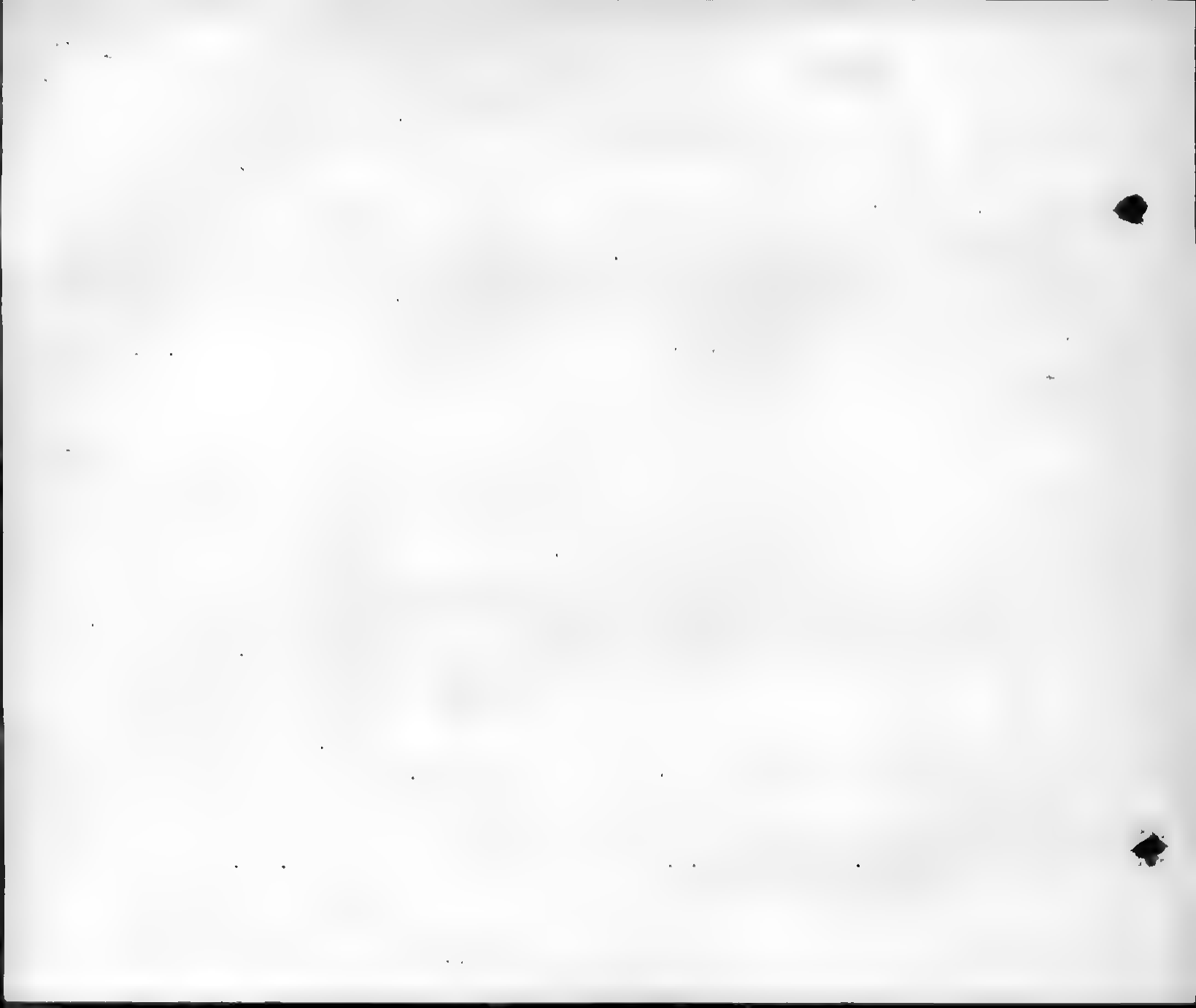
CERTIFICATE OF DEATH

Item 9 2161271 9-22-60 et

09937

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MD. b. COUNTY 1 - 1 - 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 2 yr. 5 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 BALTIMORE	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. (Cremen) Last CREMEN		4. DATE OF DEATH Month Sept Day 16 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-78
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MD., Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW O'NEIL		14. MOTHER'S MAIDEN NAME ANN MAHONEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MA/ Nutrition 450 450 DUE TO Generalized Arterio Sclerosis Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 13, 1958 to Sept 16, 1960 that (I) (we) last saw the deceased alive on Sept 16, 1960 and that death occurred at 11 PM , from the causes and on the date stated above			
22a. SIGNATURE Peter C. Y. Tchen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) PETER C. Y. TCHEN		22d. ADDRESS 116 ALLEN RD. GLEN BURNIE MD	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lamm		25a. REC'D BY REGISTRAR SEP 19 '60	
ADDRESS 4611 Park Heights Ave. Balto.		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	





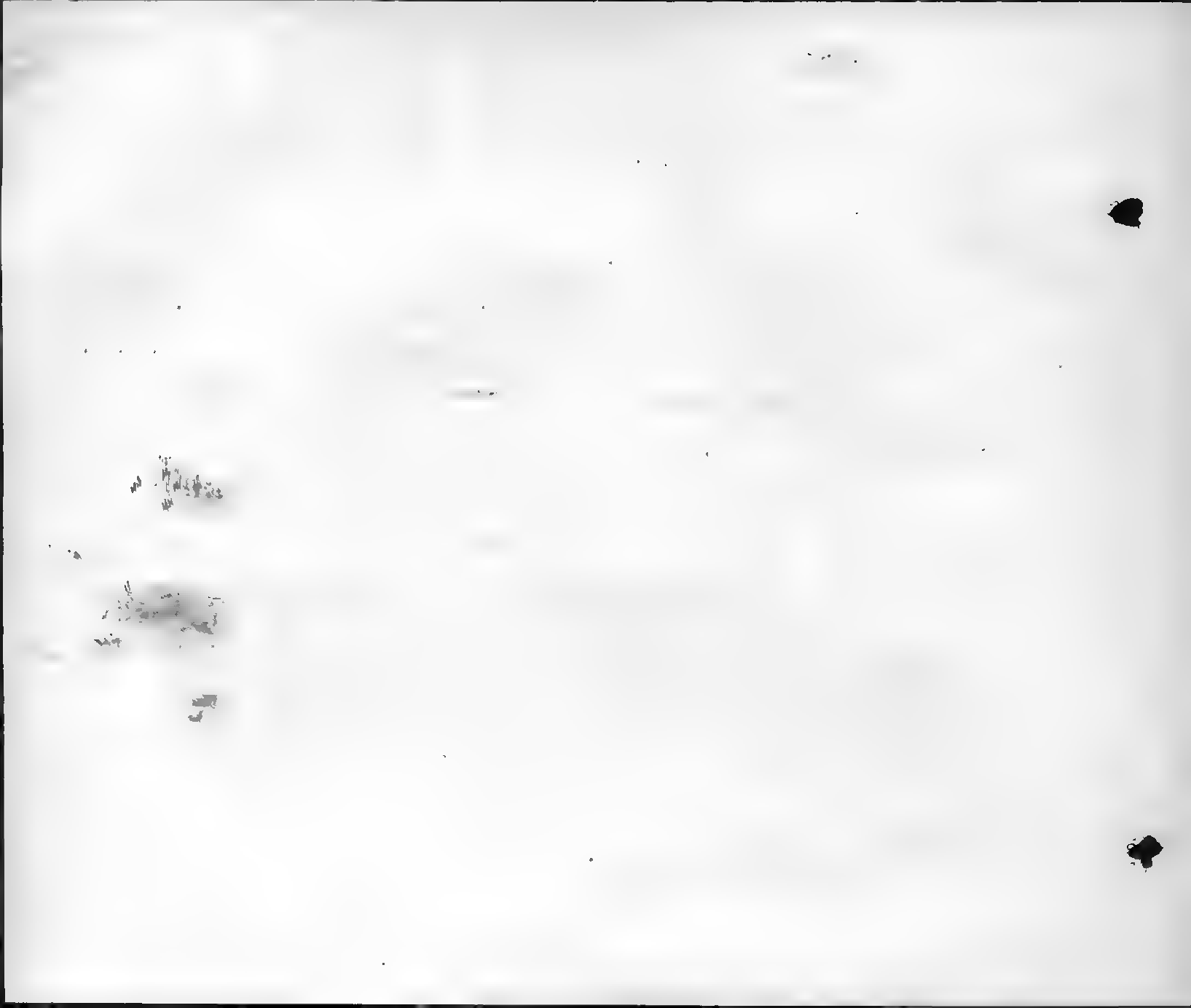
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9984
MARDYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09939

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Crubaugh		4. DATE OF DEATH Month September Day 14 Year 1960	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1877
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Utility	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Robert Crubaugh		14. MOTHER'S MAIDEN NAME Unknown Sarah E. Rankin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown no		16. SOCIAL SECURITY NO. Unknown none	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Bronchopneumonia due to bronchiectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Right-sided hypertrophy and failure of heart DUE TO (c) Pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 22 1960, to Sept. 14 1960, that (I) (we) last saw the deceased alive on Sept. 14 1960, and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar, M. D.		22b. DATE SIGNED 9-14-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 16, 1960	23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran	23d. LOCATION (City town or county) (State) Joppa, Harford, Md.,
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Mc Comas & Son		25a. REC'D BY REG-STRAR DATE SEP 19 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Finck			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

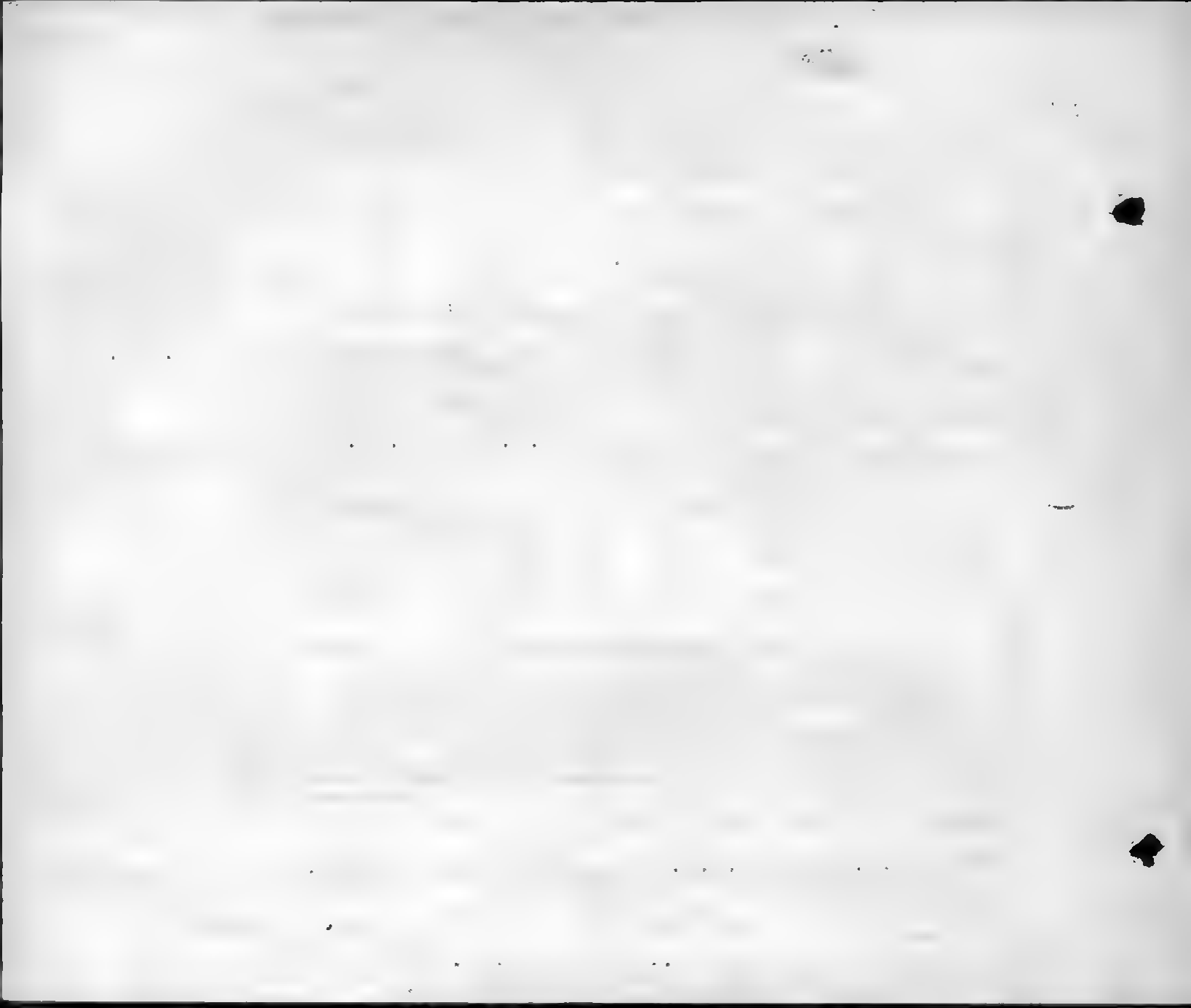
9937

CERTIFICATE OF DEATH

Reg. Dist. No.

03940

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3309 Sollers Point Road				e. STREET ADDRESS 3309 Sollers Point Road			
3. NAME OF DECEASED (Type or print) First CAMILLE Middle C. Last CURINGA				4. DATE OF DEATH Month September Day 20th Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1909	9. AGE (In years last birthday) 51 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ceaser A. Garafoli				14. MOTHER'S MAIDEN NAME Philmeno Bendict			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-05-8904		17. INFORMANT A.E. Curinga, Sr., same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/19 , 19 60 , to 9/20 , 19 60 , that I last saw the deceased alive on 9/18/60 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3401 Dundalk Avenue DATE SIGNED 9/22/60 ACTUAL SIGNATURE W.E. Baermann M.D. PHYSICIAN'S NAME (Type) W.E. Baermann, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/60		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE SEP 26 '60		24b. REGISTRAR'S SIGNATURE Clifton S. Kline	



CERTIFICATE OF DEATH

Reg. Dist. No.

9985

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN TB 36 yrs.		d. STREET ADDRESS 59 N. Prospect Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 59 N. Prospect Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Freda Middle Dorn Last		4. DATE OF DEATH Month Sept. Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Julius Haas		14. MOTHER'S MAIDEN NAME Catherine Fishback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-8147-A	
17. INFORMANT Mr. Raymond Dorn		Address St. Johns Lane Ellicott City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Regenerative P. U. D. DUE TO Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-12 , 19 60 , to 9-27 , 19 60 , that I last saw the deceased alive on 9-27-1960 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Catonsville DATE SIGNED 9-29			
ACTUAL SIGNATURE James S. Howell M.D.		PHYSICIAN'S NAME (Type) Catonsville	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/1960	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. J. Jones		24a. REC'D BY REGISTRAR DATE OCT 3 '60	
ADDRESS Catonsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9942
CERTIFICATE OF DEATH

09942

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1705 Selma Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John F. Douthirt, Sr.		4. DATE OF DEATH Sept. 17, 1960	
5. SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1861
9 AGE (in years last birthday) 99		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. salesman		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Wm. A. Douthirt 1705 Selma Avenue #27	
17 INFORMANT Wm. A. Douthirt 1705 Selma Avenue #27		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Aorta Lesion DUE TO Generalized A.S. C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized A.S. C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1958 to Sept 17, 1960 , that (I) (we) last saw the deceased alive on Aug 20, 1960 , and that death occurred at 10 M, from the causes and on the date stated above			
22a. SIGNATURE John F. Healy M.D.		22b. DATE SIGNED SEP 21 '60	
22c. PHYSICIAN'S NAME (Type) John Healy, M.D.		22d. ADDRESS Francis Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR SEP 21 '60	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Charles L. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09943

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9116 BELAIR ROAD</u>		2. USUAL RESIDENCE (Where deceased lived. If not list an Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> d. STREET ADDRESS <u>19120 BELAIR ROAD</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CELESTE</u> First <u>L</u> Middle <u>DUNTY</u> Last 4. DATE OF DEATH <u>SEPT 10</u> 19 <u>60</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JULY 26, 1891</u> 9. AGE (in years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> 11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN. DERWART</u> 14. MOTHER'S MAIDEN NAME <u>ROSE. UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO <u>NONE</u> 17. INFORMANT <u>William Duntz</u> Address <u>4138 Brookfield Ave. (6)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hyper-tensive Cardio Vascular Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John C. Hyle</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-10-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>9/13/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM PARK</u> 22d. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Sasseln Funeral Home 7701 Belair Rd. # 6 MD</u> 24a. REC'D BY REGISTRAR <u>SEP 13 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9-59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09944

9987

CERTIFICATE OF DEATH

1 PLACE OF DEATH **Rosewood St. Tr. School**
a COUNTY **Baltimore** MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore City**

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Owings Mills** c LENGTH OF STAY IN 1b **1 month**

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore City Hospital 23**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Rosewood State Training School** d. STREET ADDRESS **1714 W. Fayette St.**

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First **Bill** Middle **Easter** Last **Easter** 4. DATE OF DEATH Month **9** Day **12** Year **1960**

5 SEX **Male** 6 COLOR OR RACE **Negro** 7 MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **6-15-60** 9 AGE (in years last birthday) yrs. **3** F UNDER 1 YEAR **3** IF UNDER 24 HRS Months **3** Days **3** Hours **3** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **-** 10b. KIND OF BUSINESS OR INDUSTRY **-** 11. BIRTHPLACE (State or foreign country) **Maryland** 12 CITIZEN OF WHAT COUNTRY? **U.S.A.**

13 FATHER'S NAME **Lonnie Terry** 14. MOTHER'S MAIDEN NAME **Lucy Easter**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **-** 17 INFORMANT **Rosewood St. Tr. School, Owings Mills, Md.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Gastro-enteritis acute**
571.0 DUE TO **etiology not determined**
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **micro-cephalic idiot**
DUE TO (c) **Birth**
INTERVAL BETWEEN ONSET AND DEATH **3 weeks - Birth**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 **8-11** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from **8-11** **1960**, to **9-12** **1960**, that (I) (we) last saw the deceased alive on **9-12 @ 10:45 p.m.**, and that death occurred at **10:55 p.m.** from the causes and on the date stated above.

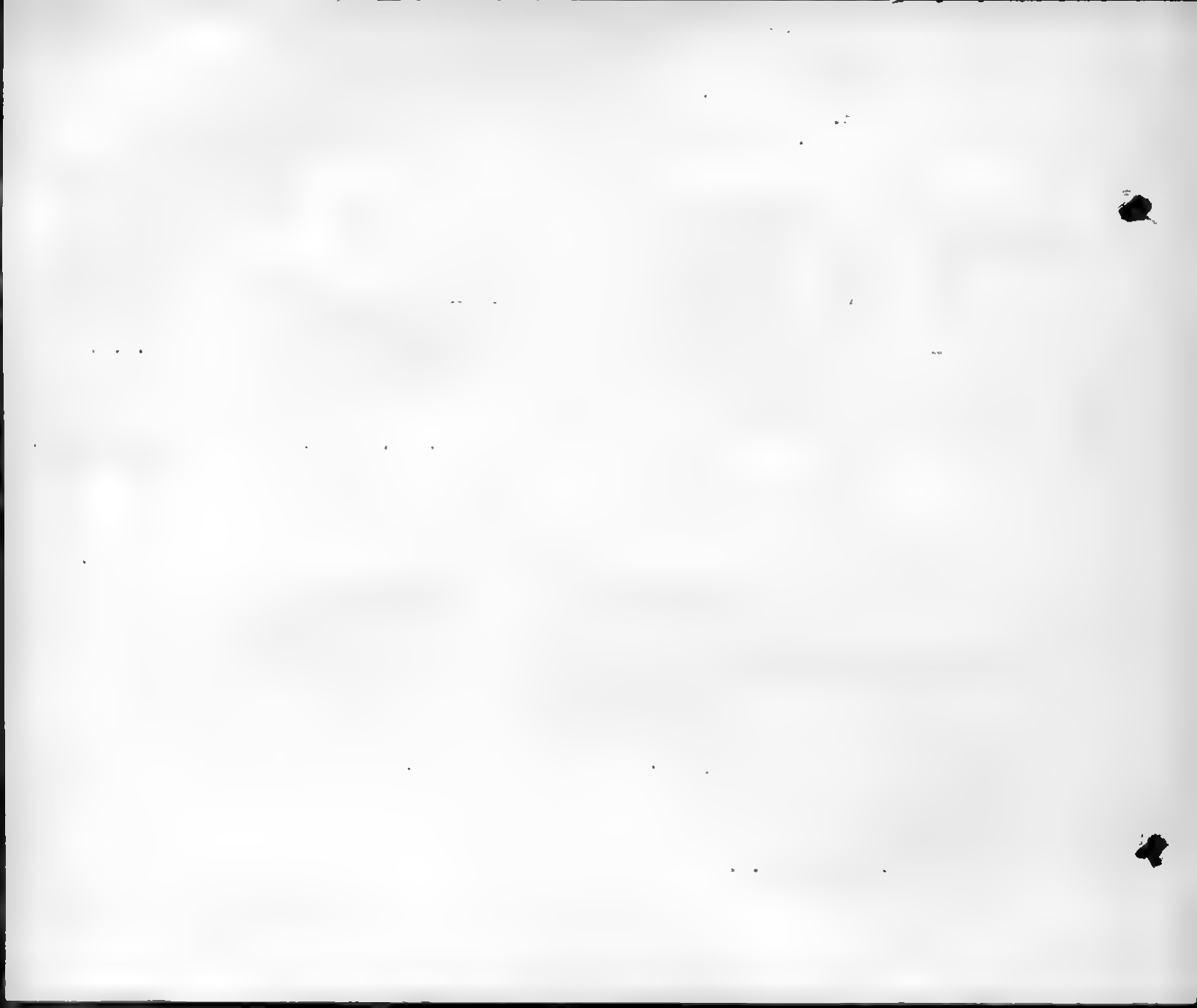
22a SIGNATURE **Harry G. Butler** M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ 22b DATE SIGNED **9-12-60**

22c PHYSICIAN'S NAME (Type) **Harry G. Butler, M.D.** 22d ADDRESS **Owings Mills, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **9/15/60** 23c. NAME OF CEMETERY OR CREMATORY **Rosewood Cem.** 23d. LOCATION (City, town, or county) (State) **Owings Mills Md**

24 FUNERAL DIRECTOR'S SIGNATURE **J. F. Eline & Sons** ADDRESS **Reisterstown Md.** 25a. REC'D BY REGISTRAR DATE **SEP 19 '60** 25b. REGISTRAR'S SIGNATURE **Arthur S. House**

1111111111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9988

CERTIFICATE OF DEATH

09945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyde, Md.		c. LENGTH OF STAY IN 1b 34 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elder Road		d. STREET ADDRESS Elder Rd	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HOWARD ELDER, SR.		4. DATE OF DEATH Month Day Year SEPT. 28 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1891 12-8-1893
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Balto., Co City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Elder		14. MOTHER'S MAIDEN NAME Frances Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W. 1 215-32-1250	
17. INFORMANT George Elder, Jr.		Address Hyde Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Coronary Insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH one-half hour 20 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to September, 1960 , that I last saw the deceased alive on 26 September, 1960 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Maryland DATE SIGNED 28 Sept. 1960			
ACTUAL SIGNATURE Walter T. Kees		PHYSICIAN'S NAME (Type) Walter T. Kees, D.	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-1-1960	
22c. NAME OF CEMETERY OR CREMATORY TRINITY CEMETERY		22d. LOCATION (City, town, or county) (State) LONG GREEN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE BROOKS FUNERAL SER. 622 YORK RD. TOWSON		24a. REC'D BY REGISTRAR OCT 4 '60	
ADDRESS BROOKS FUNERAL SER. 622 YORK RD. TOWSON		24b. REGISTRAR'S SIGNATURE C. S. Kees	



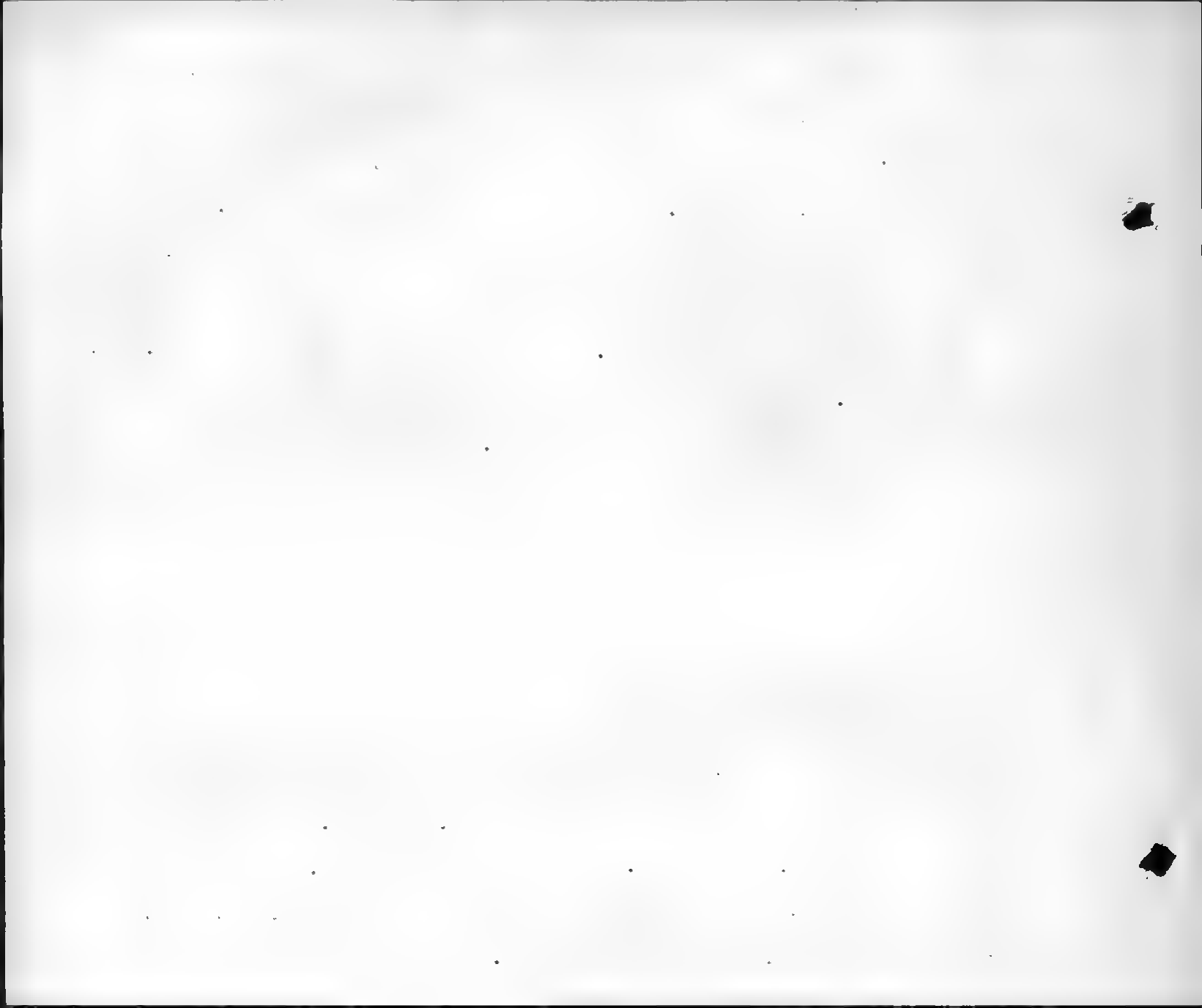
CERTIFICATE OF DEATH

Reg. Dist. No.

09946

9989

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN 1b 55 Towson 4,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 717 Goucher Blvd.				e. STREET ADDRESS 717 Goucher Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARIE WILSON ELDRIDGE				4. DATE OF DEATH Month Day Year 9-11 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1906	
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File clerk				10b. KIND OF BUSINESS OR INDUSTRY auto mfg.		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward B. Wilson				14. MOTHER'S MAIDEN NAME Carrie Ginn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Lee M. Eldridge,			
17. INFORMANT above				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 18 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1958 , 19... to death, 19... that I last saw the deceased alive on 10 Sept. , 19 60 , and that death occurred at 12³⁰ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED 12 Sept 60							
ACTUAL SIGNATURE William K. Diehl M.D.				11 E. Chase St.			
PHYSICIAN'S NAME (Type) William K. Diehl, M. D.				Baltimore 2, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Balto., 14, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				ADDRESS Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							



CERTIFICATE OF DEATH

Reg. Dist. No. 09947

9990

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>H. Sta.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanesville</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6225 Robin Hill Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lanesville</u>	
f. STREET ADDRESS <u>6225 Robin Hill Rd</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Felcher</u> Last <u>Felcher</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>24</u> Hours <u>15</u> Min <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>London, Eng</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip Traas</u>		14. MOTHER'S MAIDEN NAME <u>Ruthy</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1-11-11-11-11</u>	
17. INFORMANT <u>Samuel Felcher</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency with Failure</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County, (State)	
21. I certify that I attended the deceased from <u>Jan 1952</u> to <u>Sept 24, 1960</u> , that I last saw the deceased alive on <u>Sept 24, 1960</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Bernard R. Schuchert, MD</u> M.D. <u>6004 Park Heights Ave - #115 - 9/24/60</u>			
PHYSICIAN'S NAME (Type) <u>Bernard R. Schuchert, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Lodge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lewis</u> ADDRESS <u>2100 Eutaw Place</u>		24. REC'D BY REGISTRAR DATE <u>SEP 27 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

09948

Reg. Dist. No.

9991

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First Middle Last <u>Franklin</u>		4. DATE OF DEATH <u>September 5</u> 19 <u>60</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 23</u> 18 <u>74</u> 9. AGE (in years last birthday) <u>85</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob B. Sauder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Mrs Ella Baker</u> Address <u>Ellicott City, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident.</u> <u>422.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Degenerative Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/5/60</u> to <u>9/5/60</u> , that I last saw the deceased alive on <u>9/5/60</u> , and that death occurred on <u>9/5/60</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.E. McGroth</u>		DATE SIGNED <u>9/6/60</u>	
PHYSICIAN'S NAME (Type) <u>W.E. McGroth</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 2nd Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Scaggsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt S. Saldan</u> ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 13 1960</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



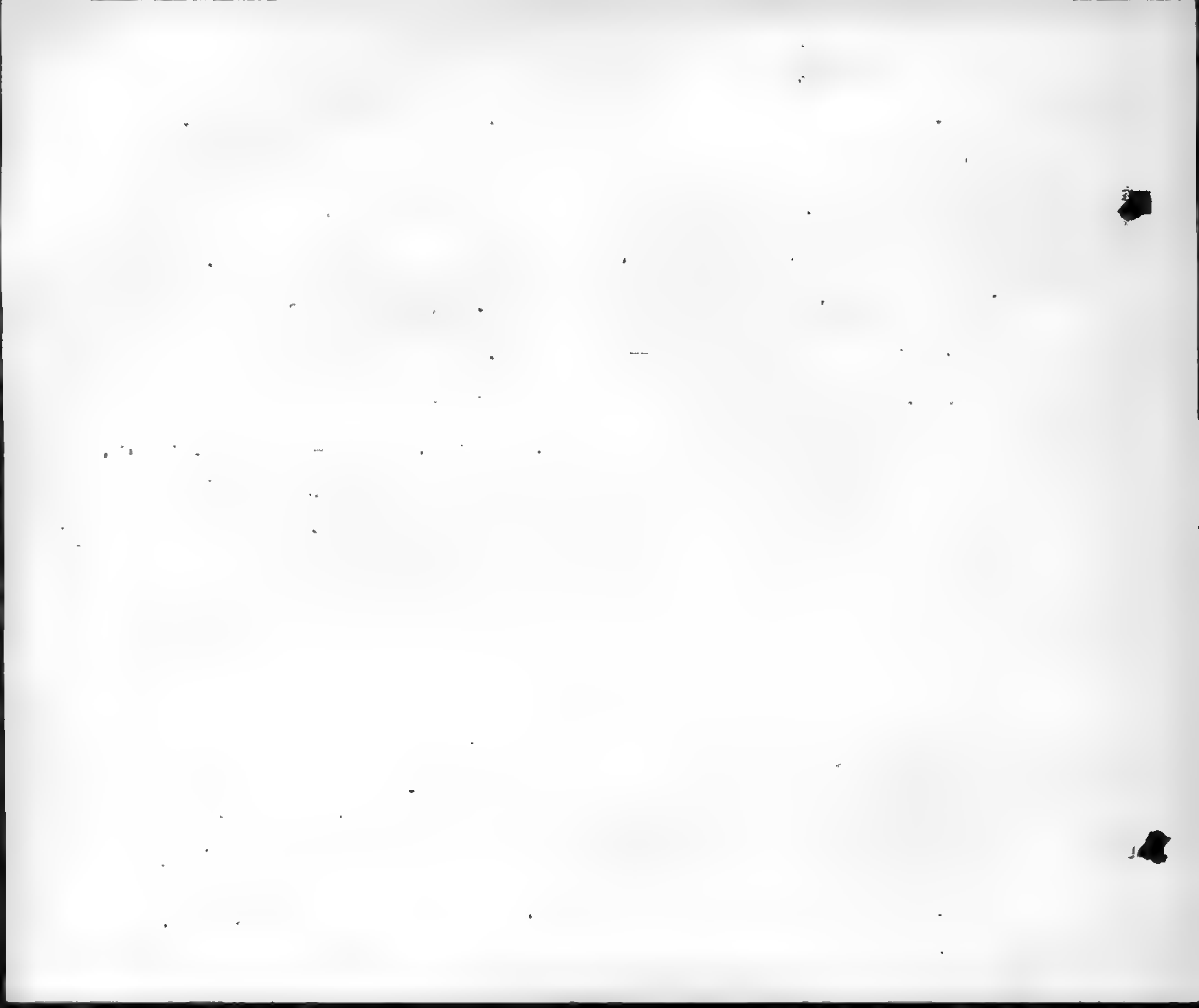
CERTIFICATE OF DEATH

Reg. Dist. No.

09950

9993

1. PLACE OF DEATH a. COUNTY Balto.				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. LENGTH OF STAY IN Ib				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				d. STREET ADDRESS 3522 Millvale Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) First Middle Last OLIVE RUTH GEIMAN				4. DATE OF DEATH Month Day Year Sept. 23, 1960				5. SEX female				6. COLOR OR RACE white				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Sept. 21, 1893				9. AGE (In years last birthday) 67 yrs				10. IF UNDER 1 YEAR Months Days Hours Min.				11. IF UNDER 24 HRS																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife								10b. KIND OF BUSINESS OR INDUSTRY Md.								11. BIRTHPLACE (State or foreign country)								12. CITIZEN OF WHAT COUNTRY?																															
13. FATHER'S NAME Benj. Stafford								14. MOTHER'S MAIDEN NAME Elizabeth ?								15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no								16. SOCIAL SECURITY NO. no								INFORMANT Mr. Edward W. Geiman - 3522 Millvale Rd.								Address															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix Uteri DUE TO (b) With Extensive Metastases DUE TO (c) about 2 yrs																INTERVAL BETWEEN ONSET AND DEATH																																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)																															
21. I certify that I attended the deceased from July 15, 1958 to Sept 22, 1960 that I last saw the deceased alive on Sept 22, 1960 and that death occurred at 4:30 M, from the causes and on the date stated above ADDRESS (Street city or town, state) 3033 W North St DATE SIGNED 17 Md																22a. BURIAL, CREMATION, REMOVAL (Specify) Burial																22b. DATE THEREOF 9/26/60								22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.								22d. LOCATION (City, town, or county) (State) Woodlawn, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tischer & Sons - Balt																24a. REC'D BY REGISTRAR DATE SEP 27 '60								24b. REGISTRAR'S SIGNATURE Robert S. Kinard																															



09951

9994 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HANOVER</u> STREET ADDRESS (If rural give location) <u>Box 104-B Race Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIAM</u> (Middle) <u>FRANK</u> (Last) <u>GILL</u>		4. DATE OF DEATH (Month) <u>SEPT.</u> (Day) <u>28</u> (Year) <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DECEASED</u>	8. DATE OF BIRTH <u>SEPT. 19 1885</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HAMILTON GILL</u>		14. MOTHER'S MAIDEN NAME <u>EMMIE KETTLEBAUGH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>UNKNOWN</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH a. IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u> b. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>GENERALIZED ARTERIO-SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>6/27</u> , 19 <u>60</u> , to <u>9/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>60</u> , and that death occurred at <u>2:40</u> A.M. from the causes and on the date stated above SIGNATURE <u>Wm. Newcomer</u> ADDRESS (Street, city, town, state) <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u> DATE SIGNED <u>9 28 60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9-30-60</u>	
NAME OF CEMETERY OR CREMATORY <u>Finksburg Cemetery</u>		LOCATION (City, town, or county) <u>Finksburg, Md</u> (State) _____	
24. REC'D BY REGISTRAR _____ REGISTRAR'S SIGNATURE <u>G. L. S. Fink</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS _____	
DATE <u>SEP 29 1960</u>			

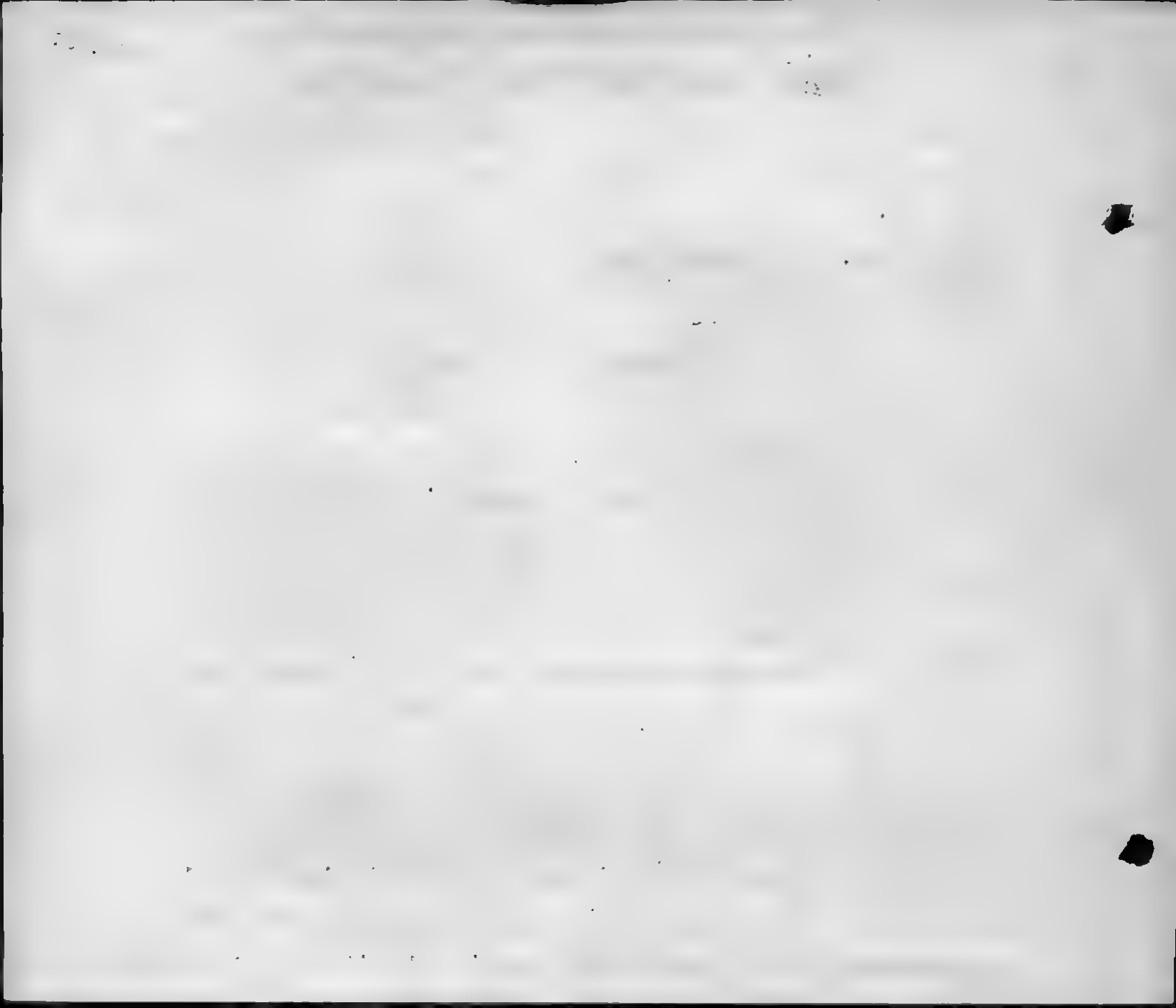
INSTRUCTIONS

1 **M** **1**

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 12 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



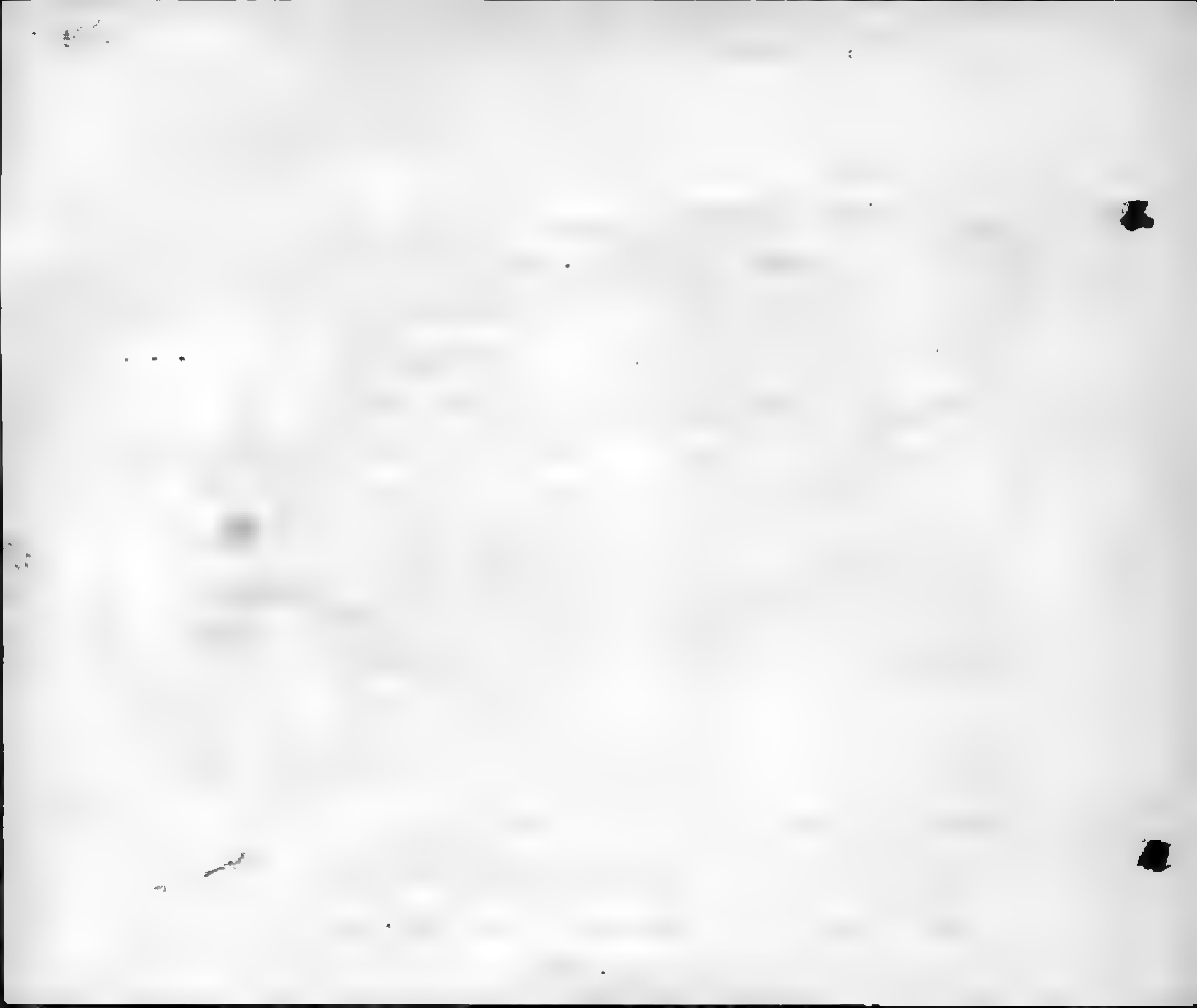
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PARKVILLE</u> <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1813 Braircliff Road</u>				d. STREET ADDRESS <u>1813 Braircliff Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick A. Goetzke SR.</u>				4. DATE OF DEATH Month Day Year <u>Sept 24 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan 1, 1914</u>		9. AGE (In years last birthday) <u>46 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		13. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>			
14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. FATHER'S NAME <u>Frederick Goetzke</u>		16. MOTHER'S MAIDEN NAME <u>Mary Marll</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War 11</u>		18. SOCIAL SECURITY NO.		19. INFORMANT Address <u>Edith Goetzke 1813 BrairCliff Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>1P</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/24/60</u>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>			
22d. LOCATION (City, town, or county) <u>Baltimore Md</u>		22e. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEO G. COOK 1701 PATTERSON EK. AVE</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9996
M
I
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09953

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street, Maryland</u>	
d. STREET ADDRESS <u>Street, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Columbus Graybeal</u>		4. DATE OF DEATH Month Day Year <u>September 1 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	
11. BIRTHPLACE (State or foreign country) <u>ASH CO North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown WINTON GRAYBEAL</u>		14. MOTHER'S MAIDEN NAME <u>Unknown AMANDA JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO <u>214-18-5620</u>	
17. INFORMANT <u>Records; SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Aug. 30, 1960</u> , to <u>Sept. 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 1, 1960</u> , and that death occurred at <u>10:00 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler, M. D.</u>		22b. DATE SIGNED <u>9-2-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/6/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Garden</u>		23d. LOCATION (City, town, or county) (State) <u>Bel Air Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kutz</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
ADDRESS <u>Farrattsville Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles C. Kutz</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

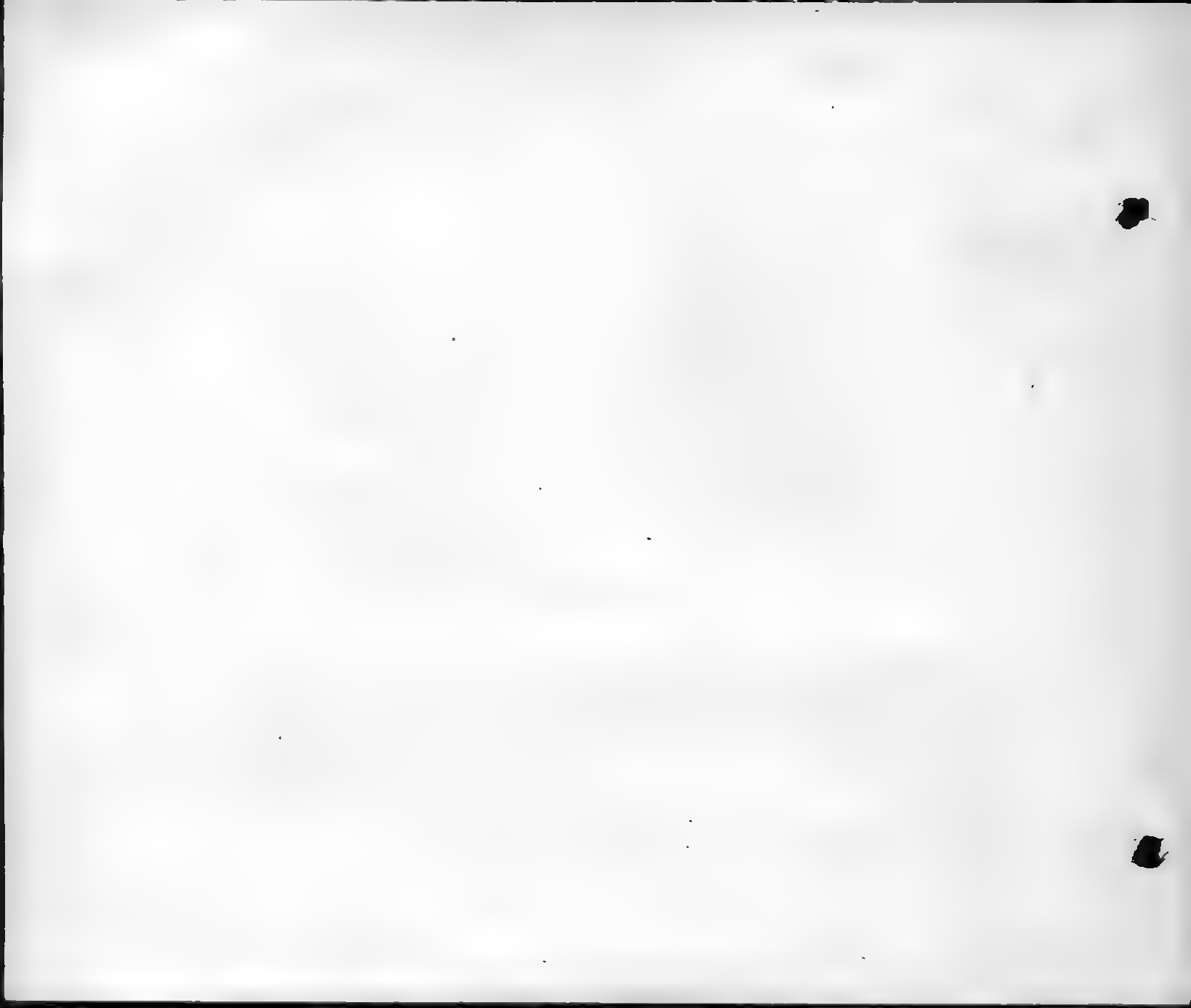
00954

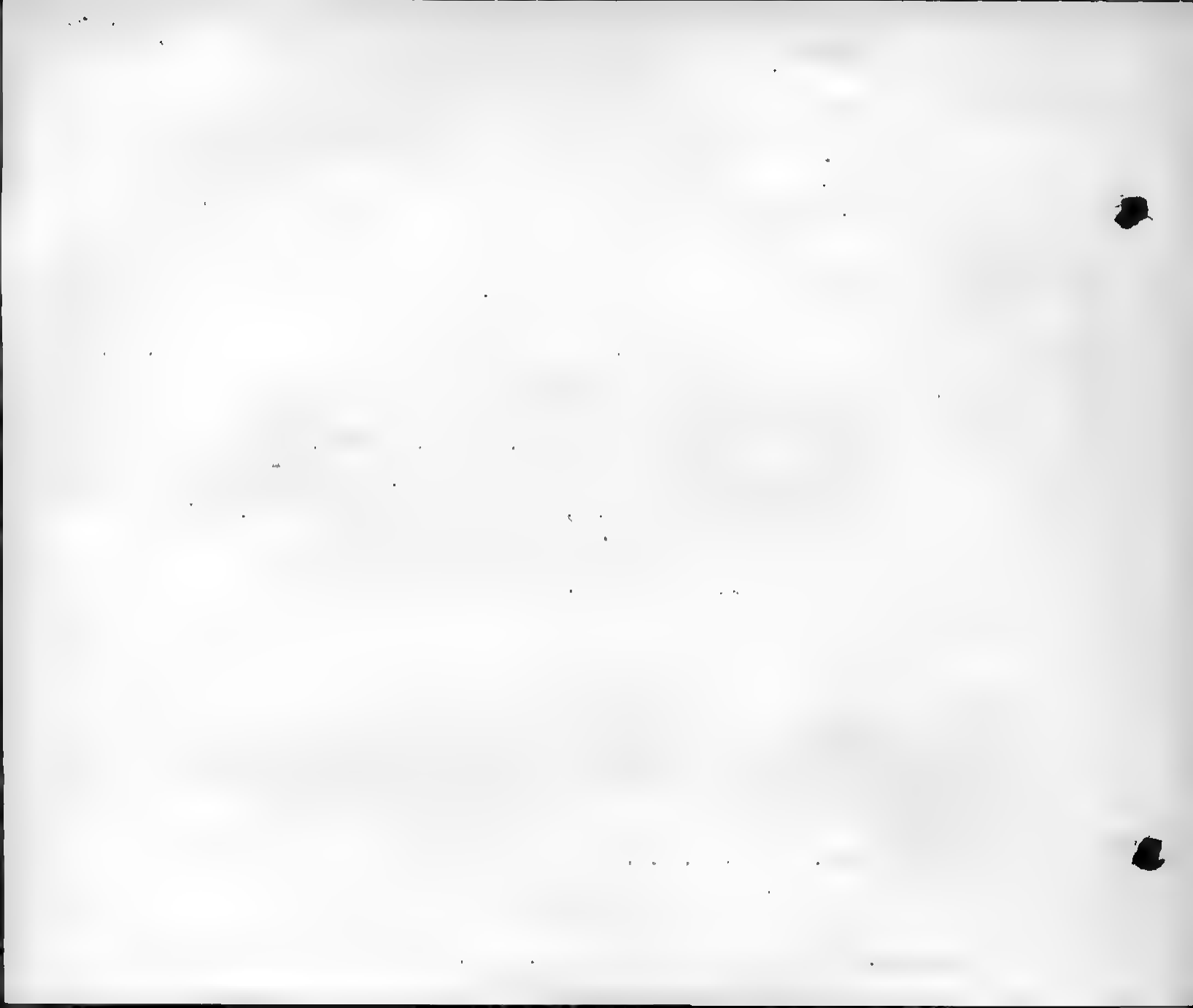
9997

Item 6 Film 6275 10 14 60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 E. Susquehanna Avenue</u>		e. STREET ADDRESS <u>110 E. Susquehanna Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Thomas</u> Last <u>Grevell</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Bar</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Grevell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Sterner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-7850</u>	
17. INFORMANT <u>Johanna R. Grevell</u>		Address <u>110 E. Susquehanna Ave. Towson 4, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8/28/60</u> to <u>9/28/60</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9/28/60</u> , and that death occurred at <u>10:30 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jerome Wilfson</u>		22b. DATE SIGNED <u>9/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL WILFSON</u>		22d. ADDRESS <u>203 E. Beebe Ave., Towson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Marie Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>		25c. REGISTRAR'S NAME <u>Arthur A. Thomas</u>	





may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



I

9999

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09956

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN lb 41 Days		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 3630 Keswick Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle R. Last HALL		4. DATE OF DEATH Month September Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1897	9. AGE (In years last birthday) yrs 63	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia	
13. FATHER'S NAME Lee Hall		14. MOTHER'S MAIDEN NAME Anna Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-18-8676		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) EPIDERMOID CARCINOMA OF POSTERIOR TONSILLAR PILLAR (c) UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH 6 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from August 18, 1960 to September 28, 1960 , that (X) (we) last saw the deceased alive on Sept. 28, 1960 , and that death occurred at 4:30 AM , from the causes and on the date stated above.					
22a. SIGNATURE <i>Frederick S. Donaldson</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 9/28/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-1-60		23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery	
				23d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Chenoweth, Jr.</i>		ADDRESS 3615-17 Chestnut Ave. Balto Md.		25a. REC'D BY REGISTRAR SEP 30 '60	
				25b. REGISTRAR'S SIGNATURE <i>William L. Hume</i>	

2. 1. 1.

2. 1. 1.

2. 1. 1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9938

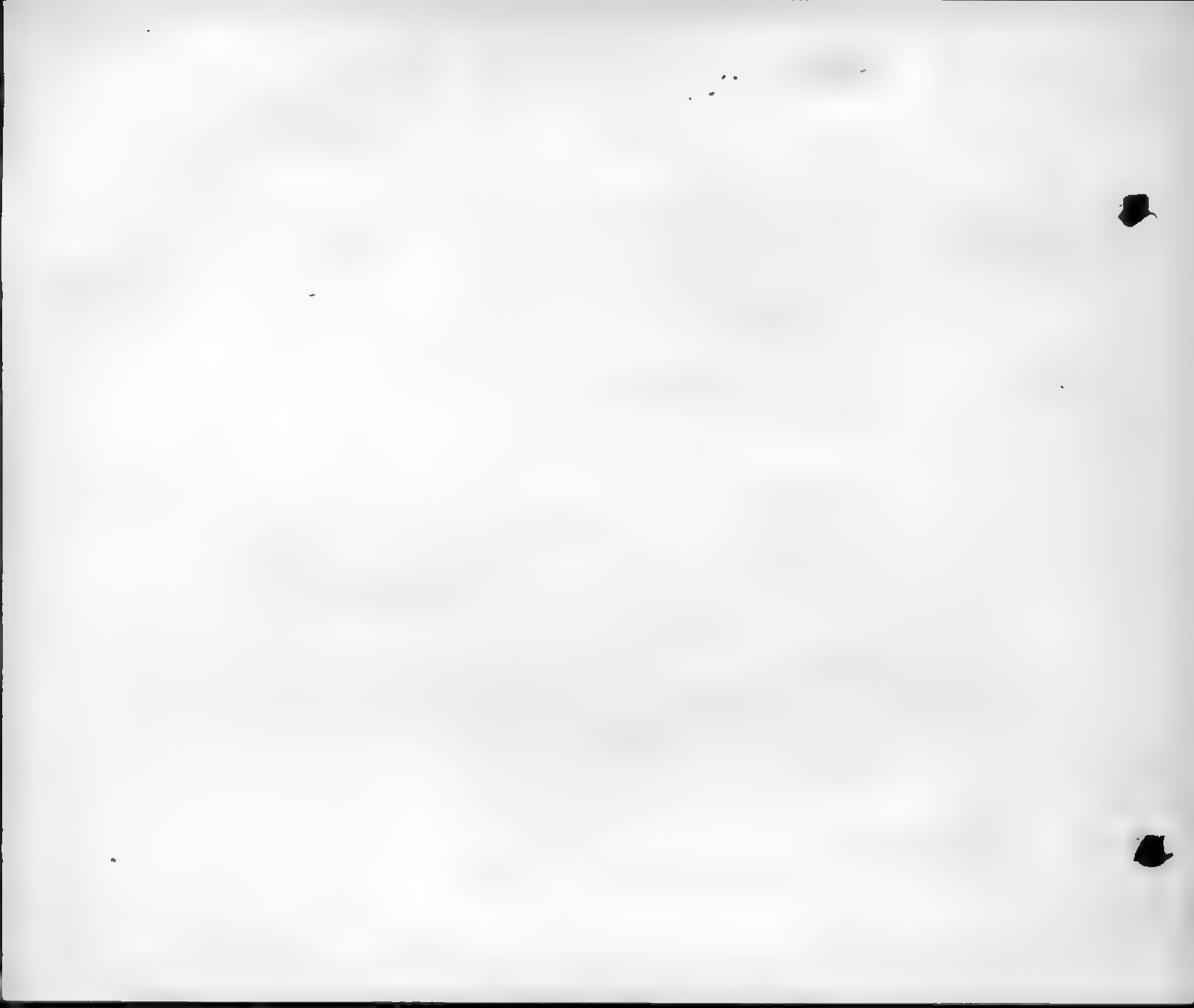
CERTIFICATE OF DEATH

69957

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	c. LENGTH OF STAY IN 1b <u>2 YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>122 WALNUT AVE.</u>		d. STREET ADDRESS <u>122 WALNUT AVE.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>ALICE JANE HAMLETT</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 1 1960</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1905</u>
9. AGE (In years last birthday) <u>55 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>PERSON CO., N C</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>STEVEN HARRIS</u>	
14 MOTHER'S MAIDEN NAME <u>NICIE CARRINGTON</u>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CORTEZ GARNETT-122 WALNUT AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>725X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Aspirin & hypertension</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Aug 21-60 to Sept 1-60</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> - Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>Aug 21-60</u> to <u>Sept 1-60</u> that I last saw the deceased alive on <u>Sept 1-60</u> 19 <u>60</u> and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>107 N. Main St. Balto 22 MD</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		M.D. <u>107 N. Main St. Balto 22 MD</u>	
PHYSICIAN'S NAME (Type) <u>D.H. Thomas</u>		<u>Balto 22 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. PISCATAWAY</u>	22d. LOCATION (City, town, or county) (State) <u>South Boston, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Linn</u>		ADDRESS <u>802 N. Main St. Balto, Md.</u>	24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

100000

1

09958

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 21 Days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 2234 Guilford Avenue		
3. NAME OF DECEASED (Type or print) First OLLIE Middle J. Last HAMLIN			4. DATE OF DEATH Month September Day 13 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE, 7, 1897	9. AGE (In years last birthday) 63 y/s.	10. IF UNDER 1 YEAR Months 1 Days 13 Hours 19 Min 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Janitor	11. BIRTHPLACE (State or foreign country) Dendron, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Hamlin			14. MOTHER'S MAIDEN NAME Rose Stringfield		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I	17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ESOPHAGEAL VARIX WITH MASSIVE HEMORRHAGE IN THE STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOSIS OF THE MIDDLE CEREBRAL ARTERY (c) MARKED CEREBRAL ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH 3 HOURS UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Maryland	(State) Maryland
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 23, 1960 to September 13, 1960 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Sept. 13, 1960 , and that death occurred at 9:30 p.m. from the causes and on the date stated above					
22a. SIGNATURE Frederick S. Donaldson		M. D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/14/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/19/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) Baltimore	(State) Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Locks Funeral Home		ADDRESS 304 N. Central Ave. Balto. Md.		25a. REC'D BY REGISTRAR DATE SEP 19 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

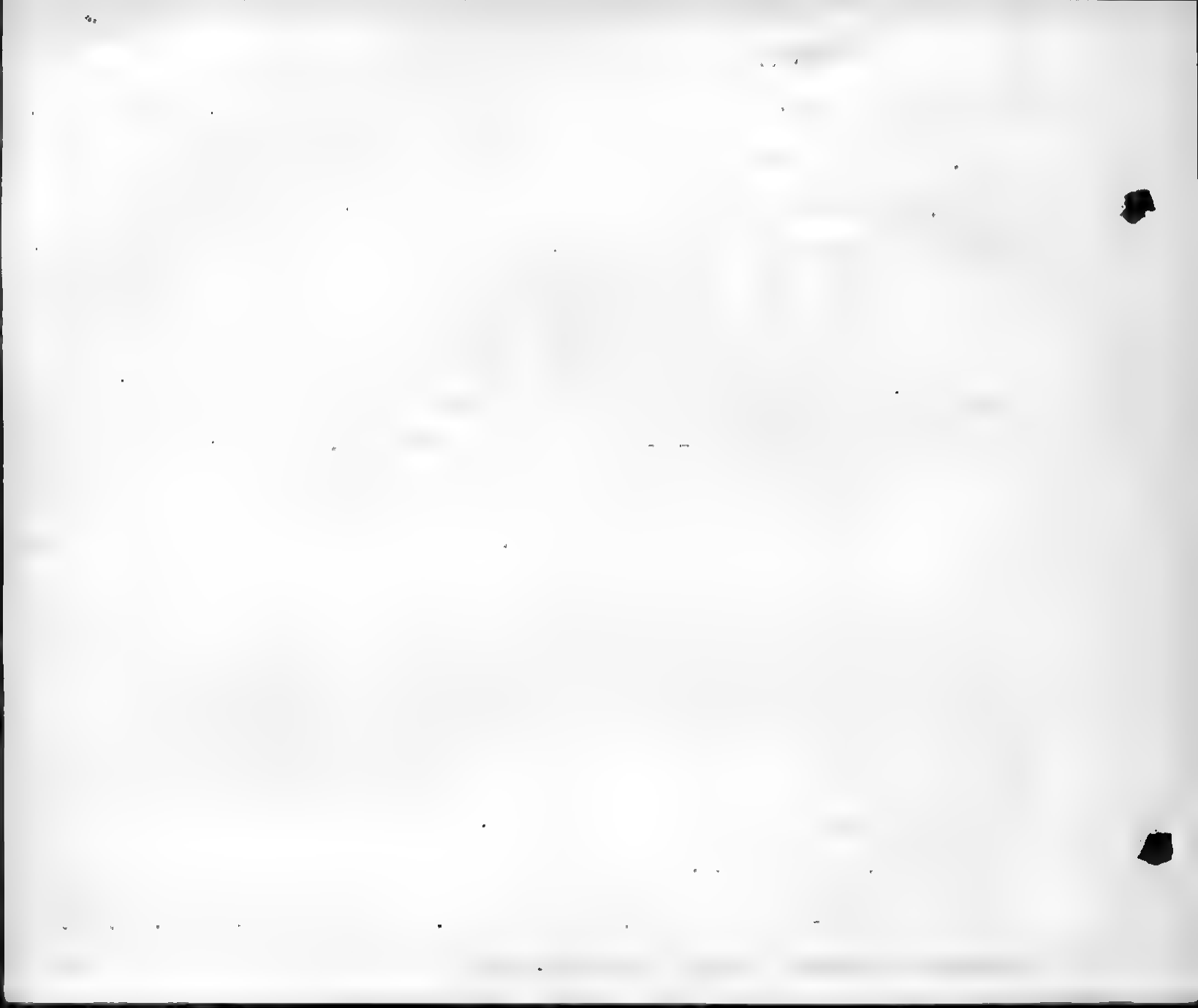
09959

10001

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland	c. LENGTH OF STAY IN 1b 4 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mr. Wilson State Hospital		d. STREET ADDRESS 4115 Link Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DAVID First CLEVELAND Middle HARE Last		4. DATE OF DEATH Sept. Month 29 Day 19 Year 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1887
9. AGE (in years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM HARE	
14. MOTHER'S MAIDEN NAME REBECCA CRAUNER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-32-1456		INFORMANT Address Hospital Records, Mt. Wilson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 1887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH over 2 yrs over 5 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderately advanced pulmonary tuberculosis (1887)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-26-1960 to 9-29-1960 that I last saw the deceased alive on 9-29-1960 , and that death occurred at 11:48 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 9-29-1960	
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-1960	
22c. NAME OF CEMETERY OR CREMATORY Sr. Michael's Luth.		22d. LOCATION (City, town, or county) (State) Perry Hall, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louise Funeral Home		24a. REC'D BY REGISTRAR Oct 3 '60 DATE	
24b. REGISTRAR'S SIGNATURE John S. Knead			



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

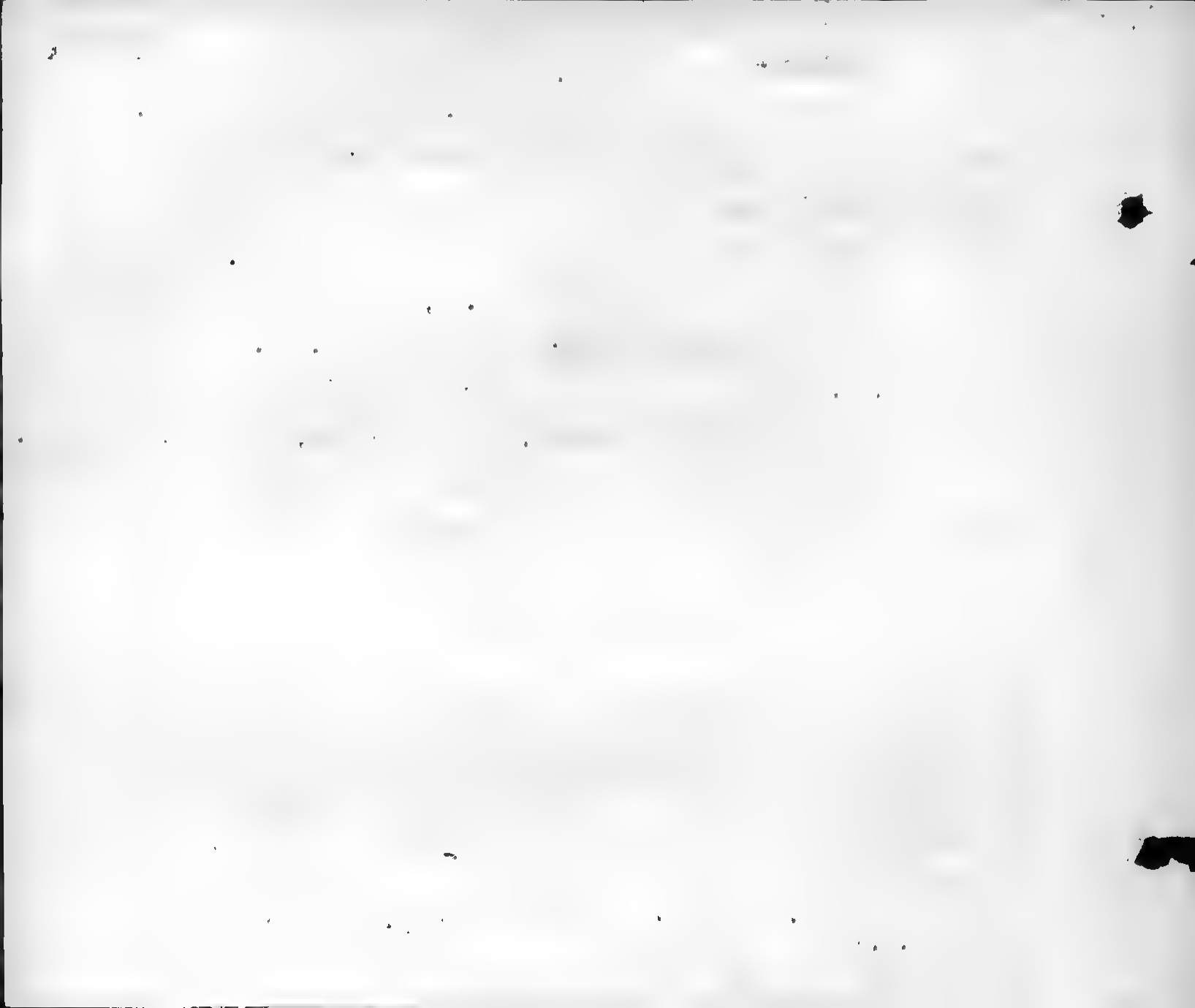
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
5
M
10002
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09960

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6133 Regent Park Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Glenn Harne				4. DATE OF DEATH Month Sept. Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1897	9. AGE (in years last birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY University Md. Medical School		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William D. L. Harne				14. MOTHER'S MAIDEN NAME Katherine Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220 36 5254			
17. INFORMANT Mrs. Edna Mae Harne				Address 6133 Regent Park Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Carcinoma of the Urinary Bladder Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 yrs (c) 6 yrs							INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/27, 1960 to 9/12, 1960 that (I) (we) lost 9/12, 1960 and that death occurred at 9 PM , from the causes and on the date stated above							
22a. SIGNATURE William G. Esmond M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM G. ESMOND				22d. ADDRESS 5018 Balt. National Pike			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 6/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Church Cnty. Garfield, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. #101 Edmondson Ave				25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kneel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event within 72 hours after death.

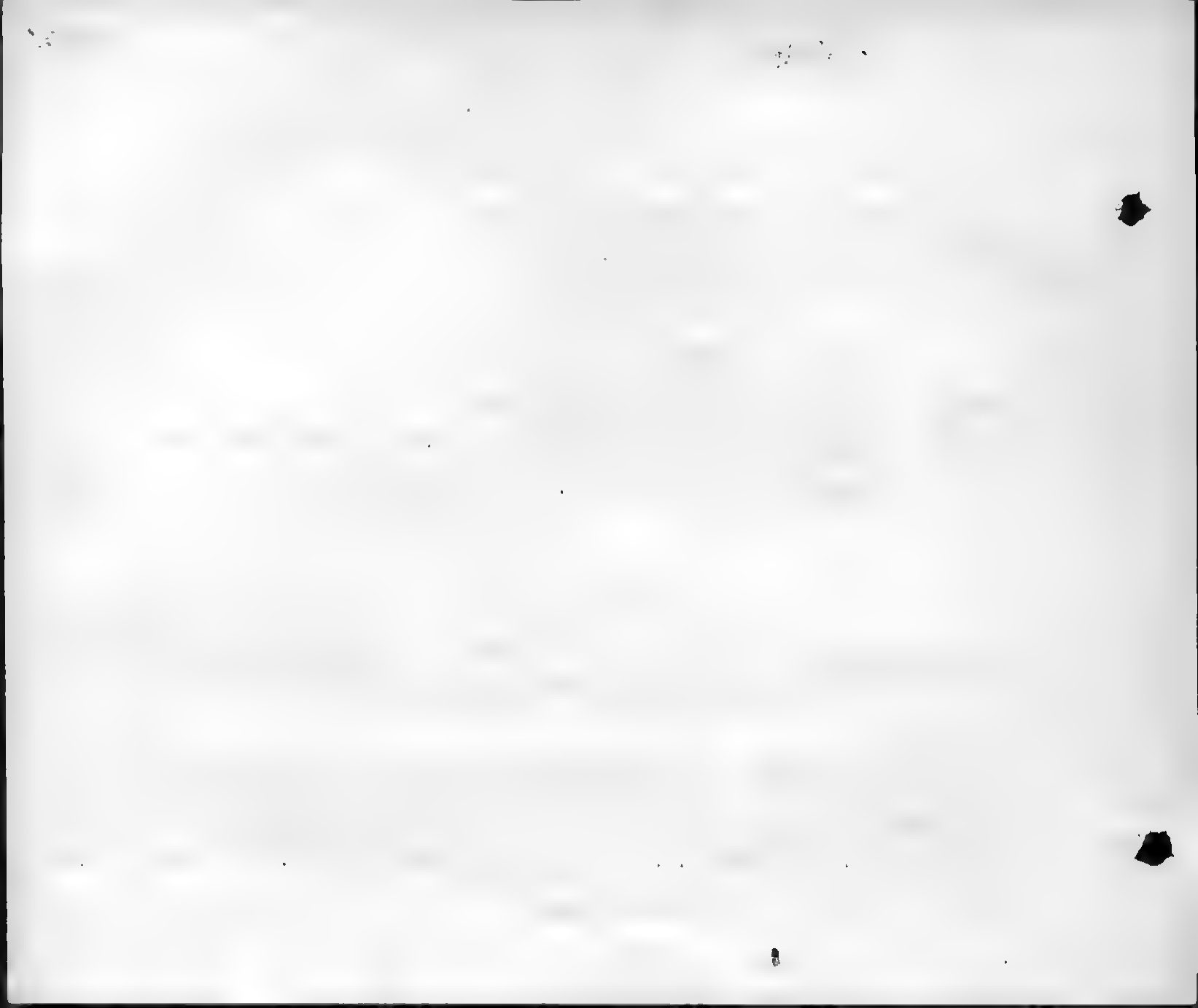
VR A15 (4)
15M 9/59

10003

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09961

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUTHER Middle R. Last HARNER				4. DATE OF DEATH Month September Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1894		9. AGE (In years lost birthday) yrs 66	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Harner				14. MOTHER'S MAIDEN NAME Mary C. MN: Ott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Yes WW I		16. SOCIAL SECURITY NO. 217-12-2070		17. INFORMANT Address Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 11, 1960 to Sept. 13, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 13, 1960 , and that death occurred at 5:25 A. M. from the causes and on the date stated above							
22a. SIGNATURE Frederick S. Donaldson M.D.				22b. DATE SIGNED 9/13/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1960		23c. NAME OF CEMETERY OR CREMATORY Lutheran Church Cemetery		23d. LOCATION (City, town, or county) (State) Harney Carroll Co Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland				25a. REC'D BY REGISTRAR SEP 15 '60		25b. REGISTRAR'S SIGNATURE <i>Robert A. Hanna</i>	



10004

CERTIFICATE OF DEATH

09962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines - 16 Fusting Ave.		d. STREET ADDRESS formerly of Wyman Pk. Apts.	
3. NAME OF DECEASED (Type or print) First BESSIE Middle B. Last HAWBAKER		4. DATE OF DEATH Month Sept. Day 18, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1878
9. AGE (In years last birthday) 82 Yrs		10. UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	11. UNDER 24 HRS Months 8 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Secretary		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George B. Hawbaker		14. MOTHER'S MAIDEN NAME Clarissa E. Ziegler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. A-246182	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis & previous episode. DUE TO (c) Hypertension. C.V.D.		INTERVAL BETWEEN ONSET AND DEATH 1 hour. few months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 25 , 19 60 , to Sep 18 , 19 60 , that I last saw the deceased alive on Sep 18 , 19 60 , and that death occurred at 11:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Bernard J. Cohen M.D.			
PHYSICIAN'S NAME (Type) Bernard J. Cohen, M.D. 3501 St. Paul St., Balto. 18, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Green Castle, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lieberman		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



CERTIFICATE OF DEATH

Reg. Dist. No.

99963

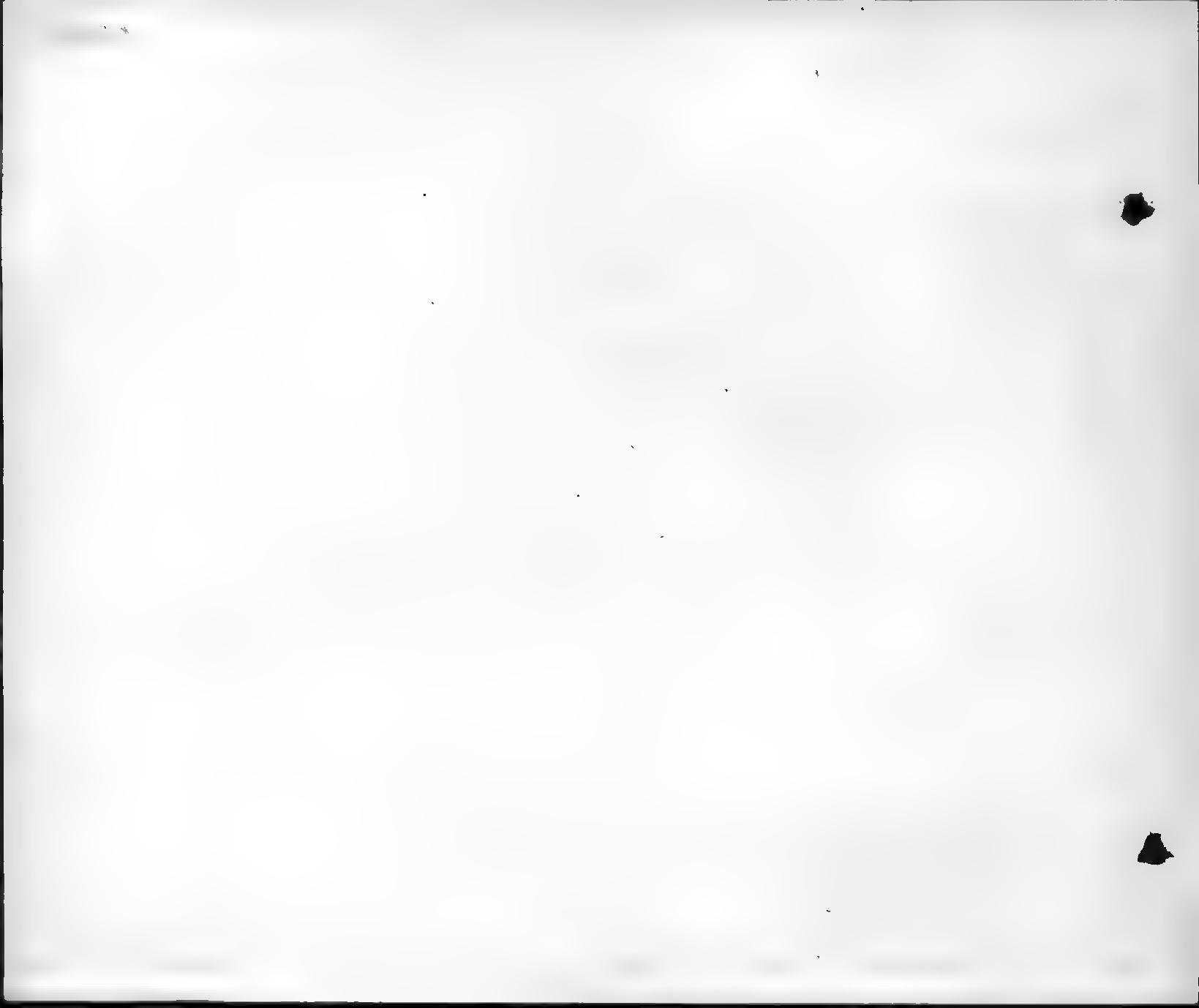
10005

1 PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosevale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>1119 Chesaco Ave.</u>		d. STREET ADDRESS <u>1119 Chesaco Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Charles Joseph Hersl</u>		4. DATE OF DEATH Month Day Year <u>Sept. 16 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 11, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James Hersl</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WWI</u>		16 SOCIAL SECURITY NO. <u>210-09-6377</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> DUE TO <u>H.C.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7⁰²</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Schulz M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>8019 Philia Rd. Balt. 6, Md.</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>9/17/60</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b DATE THEREOF <u>9-20-60</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemen Cem.</u>		22d LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Crach</u> ADDRESS <u>1211 Chesaco Ave.</u>		24a REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

09964

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2617 Hillcrest Ave.		d. STREET ADDRESS 2617 Hillcrest Avenue	
3. NAME OF DECEASED (Type or print) First William Middle Ellis Last Hewitt		4. DATE OF DEATH Month 9 Day 3 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 19, 1888
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR: Months 7 Days 1 Hours 3 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hewitt		14. MOTHER'S MAIDEN NAME Elizabeth Meredith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 215-10-9497	
17. INFORMANT Mrs. Bessie M. Hewitt		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 min 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1960, to Sept 3 , 1960, that I last saw the deceased alive on Aug , 1960, and that death occurred at 4 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6077 Harford Rd DATE SIGNED Balto. 14, Md			
ACTUAL SIGNATURE R Donald Jandorf M.D.		DATE SIGNED Balto. 14, Md	
PHYSICIAN'S NAME (Type) R Donald Jandorf		DATE SIGNED Balto. 14, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/6/60	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK		ADDRESS 5305 Harford Rd.	
24a. REC'D BY REGISTRAR SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9943

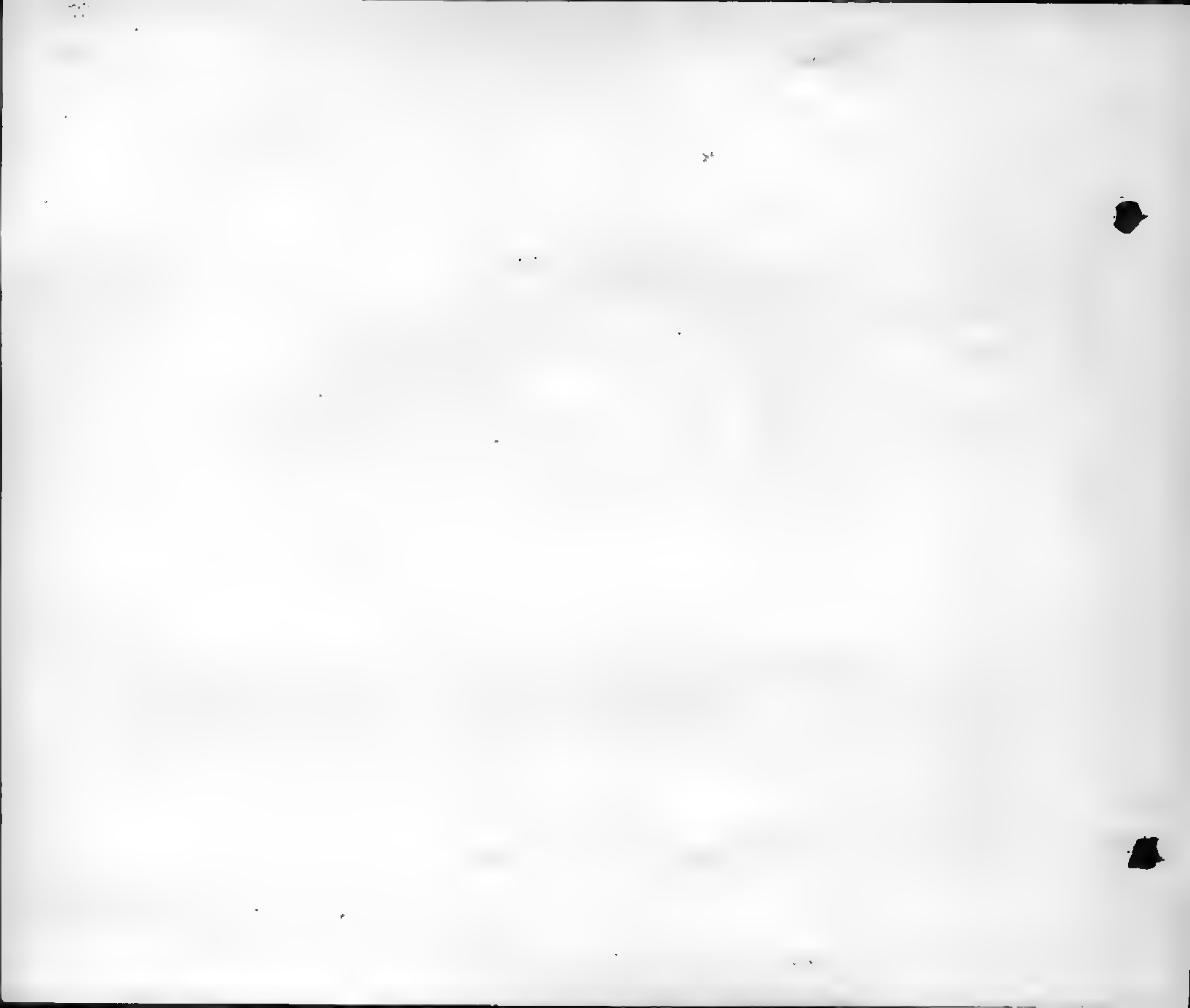
99965

9943

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>1259 Vogt Ave.</u>				d. STREET ADDRESS <u>1259 Vogt Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard J. Hickman Sr.</u>				4. DATE OF DEATH Month Day Year <u>September 19 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31, 1906</u>	
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Shop</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Robert B. Hickman</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Randall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-1997</u>		17. INFORMANT Address <u>Mrs A. Thressen 1246 Graystone Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Melanoma</u> DUE TO (b) <u>Metastasis To Lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 3 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 16 1958</u> to <u>Sept 19 1960</u> that (I) <u>we</u> lost saw the deceased alive on <u>Sept 19 1960</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>James A. Donkus</u> M.D.				22b. DATE SIGNED <u>Sept 19 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>James A. Donkus</u>				22d. ADDRESS <u>101 E. Preston St.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore</u>		23d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Embros, Inc. 1325 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	



FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the hospital or attending physician, may be furnished with a copy of this certificate. The funeral director should be furnished with a copy of this certificate so that the funeral papers may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.



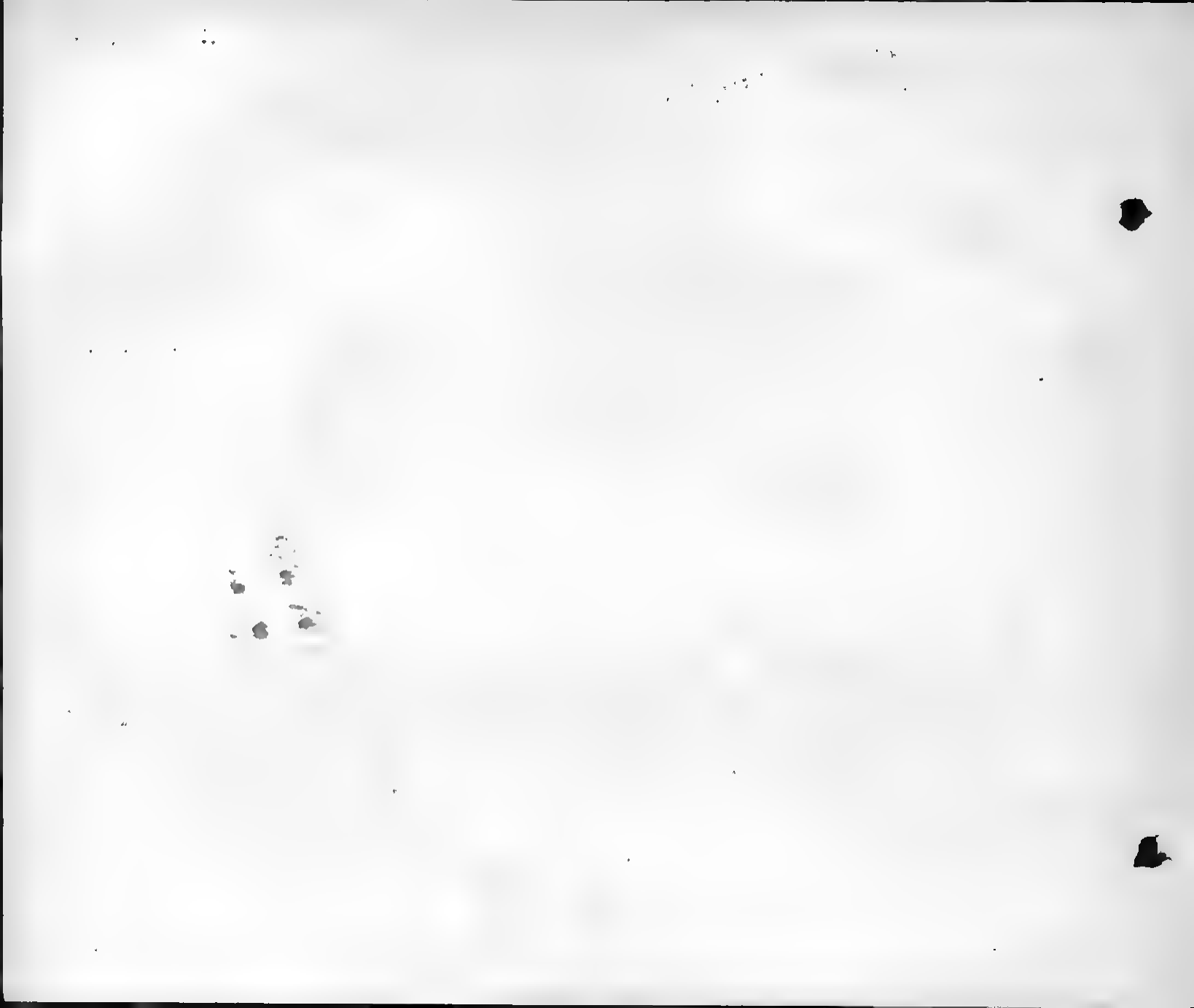
in 72 hours

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09966

10007

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mths6dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3520 Overview Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Fannie Higger		4. DATE OF DEATH Month Day Year September 6 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1893
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Mitnick		14. MOTHER'S MAIDEN NAME Bessie Schriver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-07-1869	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-13-1960 to Sept. 6, 1960 , that (I) (we) last saw the deceased alive on Sept. 6, 1960 , and that death occurred at 1:15 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar, M. D.		22b. DATE SIGNED 9-6-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) 17-7-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mount Hope		23d. LOCATION (City, town, or county) (State) Frederick Md	
24. FUNERAL DIRECTOR'S SIGNATURE Frank Lewis Jr.		25a. REC'D BY REGISTRAR DATE SEP 7 '60	
ADDRESS 3100 Gutter Place		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

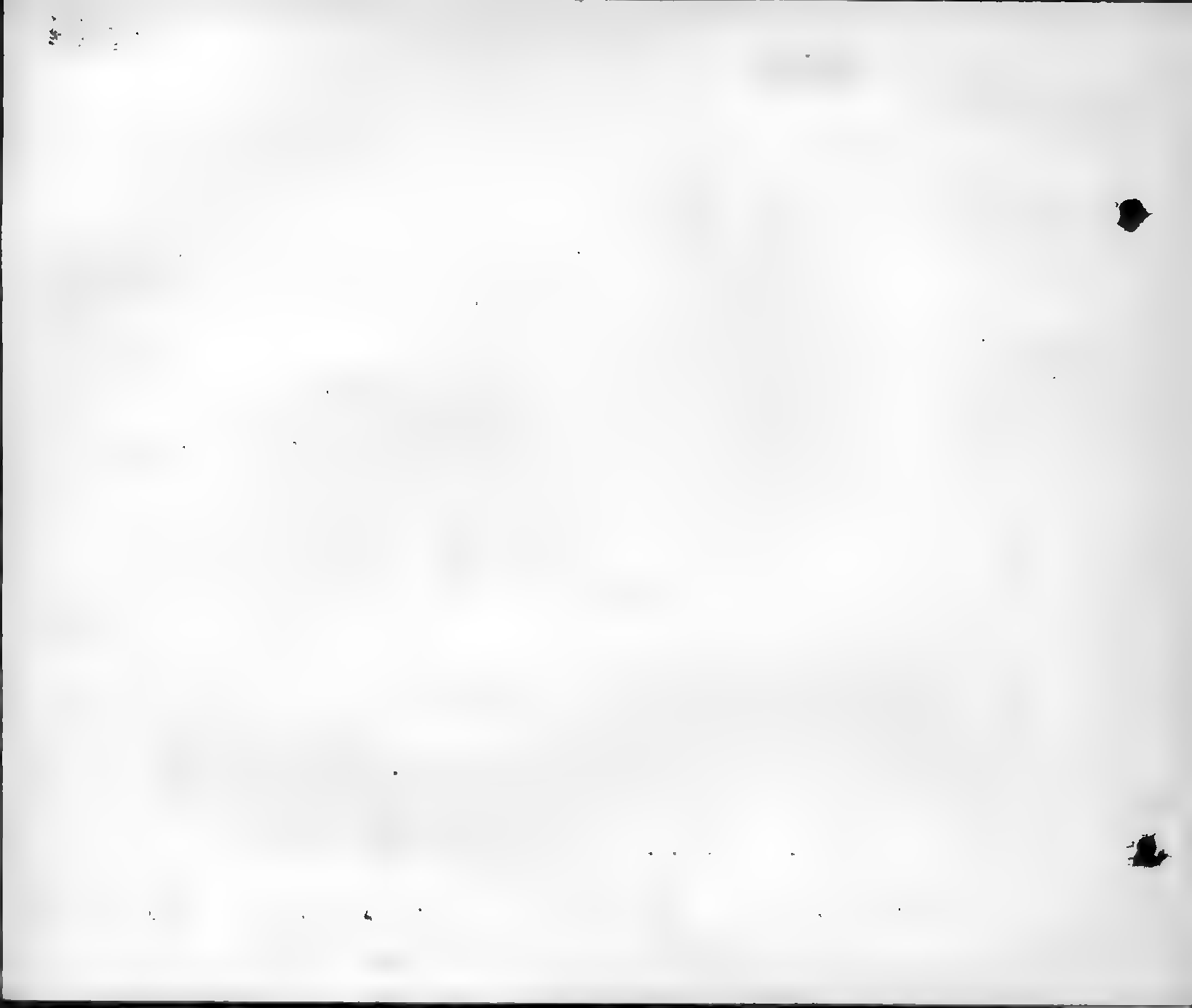


may be filled in by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
9944
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>38 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1243 Francis Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Hildebrand</u> Last <u></u>		4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 29, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Margaret Tubbs</u>		Address <u>1243 Francis Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Carcinoma of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>Sept 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 10, 1960</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Healy</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>John C. Healy, M.D.</u>		22d. ADDRESS <u>1305 Francis Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/19/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1328 Sulphur Spring Rd.</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>SEP 19 '60</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10008

CERTIFICATE OF DEATH

09968

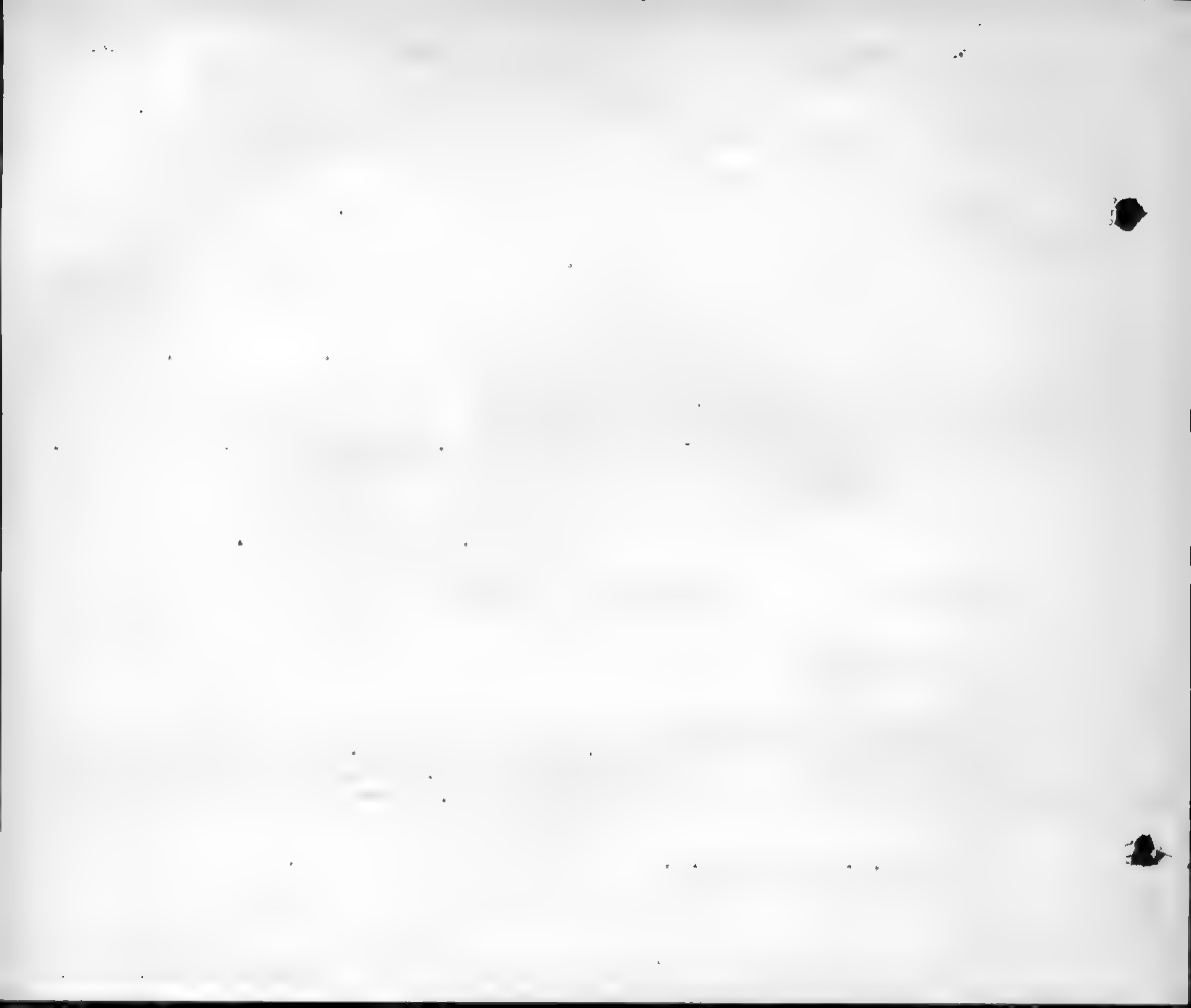
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Robert Ave.</u>		d STREET ADDRESS <u>13 Robert Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>William James Hill Jr.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1883</u>
9 AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Extractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Hill Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Slaughter</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-03-1570</u>	
17. INFORMANT <u>Lillian B. Johnson</u>		Address <u>712 Edmondson Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amputation of Rt Leg. (Gangrene)</u> DUE TO <u>Arteriosclerotic Heart Disease & right Side Hemiplegia</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>19 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 6th, 1957</u> to <u>Sept. 11th, 1960</u> , that I last saw the deceased alive on <u>Sept. 11th, 1960</u> , and that death occurred at <u>12.30 PM</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>C. F. Maloney M.D.</u>		DATE SIGNED <u>9/11/60</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		<u>Catonsville 28. Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter-3035 W. North Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. If an please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

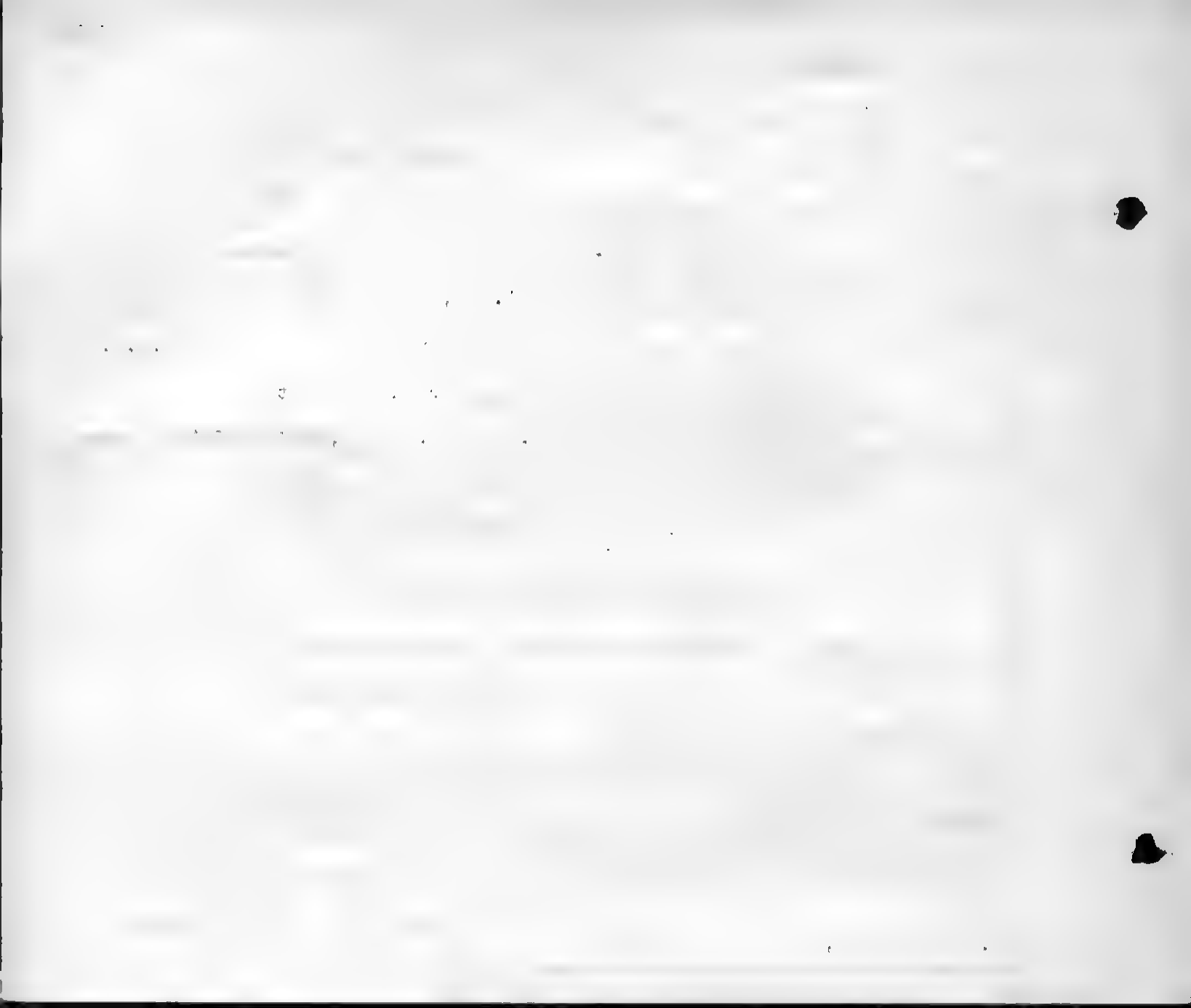
09969

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3003 Woodside Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle C. Last Hohne		4. DATE OF DEATH Month September Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Hohne		14. MOTHER'S MAIDEN NAME Albertina Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-01-3102	
17. INFORMANT Mrs. Anna B. Hohne		Address 3003 Woodside Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, colon with 53 DUE TO abdominal metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 14 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 10, 1959 to 9/19, 1960 , that I last saw the deceased alive on 9/18, 1960 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan Wainey		DATE SIGNED 9/20/60	
PHYSICIAN'S NAME (Type) Dr. Nathan Wainey		ADDRESS (Street, city or town, State) 7101 Harford Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-22-60	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, 6009 Harford Road		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
24b. REGISTRAR'S SIGNATURE L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



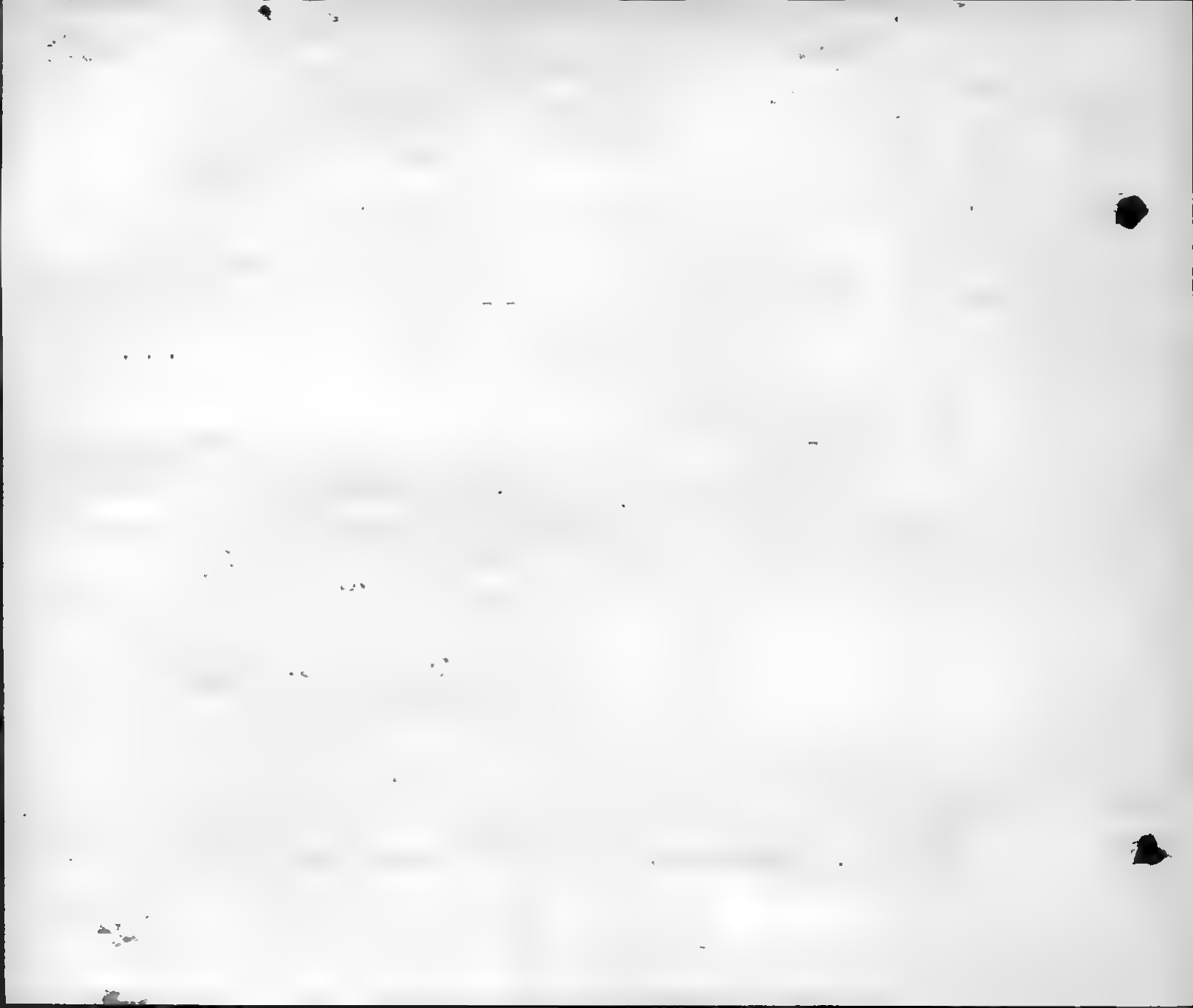
may be recorded by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10010
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
Item 14
CERTIFICATE OF DEATH

05370

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 52 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 318 NORTH POINT ROAD	
3. NAME OF DECEASED (Type or print) First ANTON Middle August Last HOLZHEID		4. DATE OF DEATH Month SEPTEMBER Day 11 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-24
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. 11. IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TRANSFER COMPANY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HOLZHEID		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO 212-03-7124	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RUPTURE MYOCARDIUM WITH HEMOPERICARDIUM IN OLD MYOCARDIAL INFARCTION Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA, RIGHT LOWER LOBE (c) WITH METASTASIS TO LIVER		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from July 21 7:05 19 60 , to Sept 11 19 60 , that I (we) last saw the deceased alive on Sept 11 19 60 , and that death occurred 7:05 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-15-60	
23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE John A Moran Funeral Home		25a. REC'D BY REGISTRAR 3000 E Baltimore St Baltimore 24 Md	
25b. REGISTRAR'S SIGNATURE Charles S. Harris		DATE SEP 15 '60	

2



10011

CERTIFICATE OF DEATH

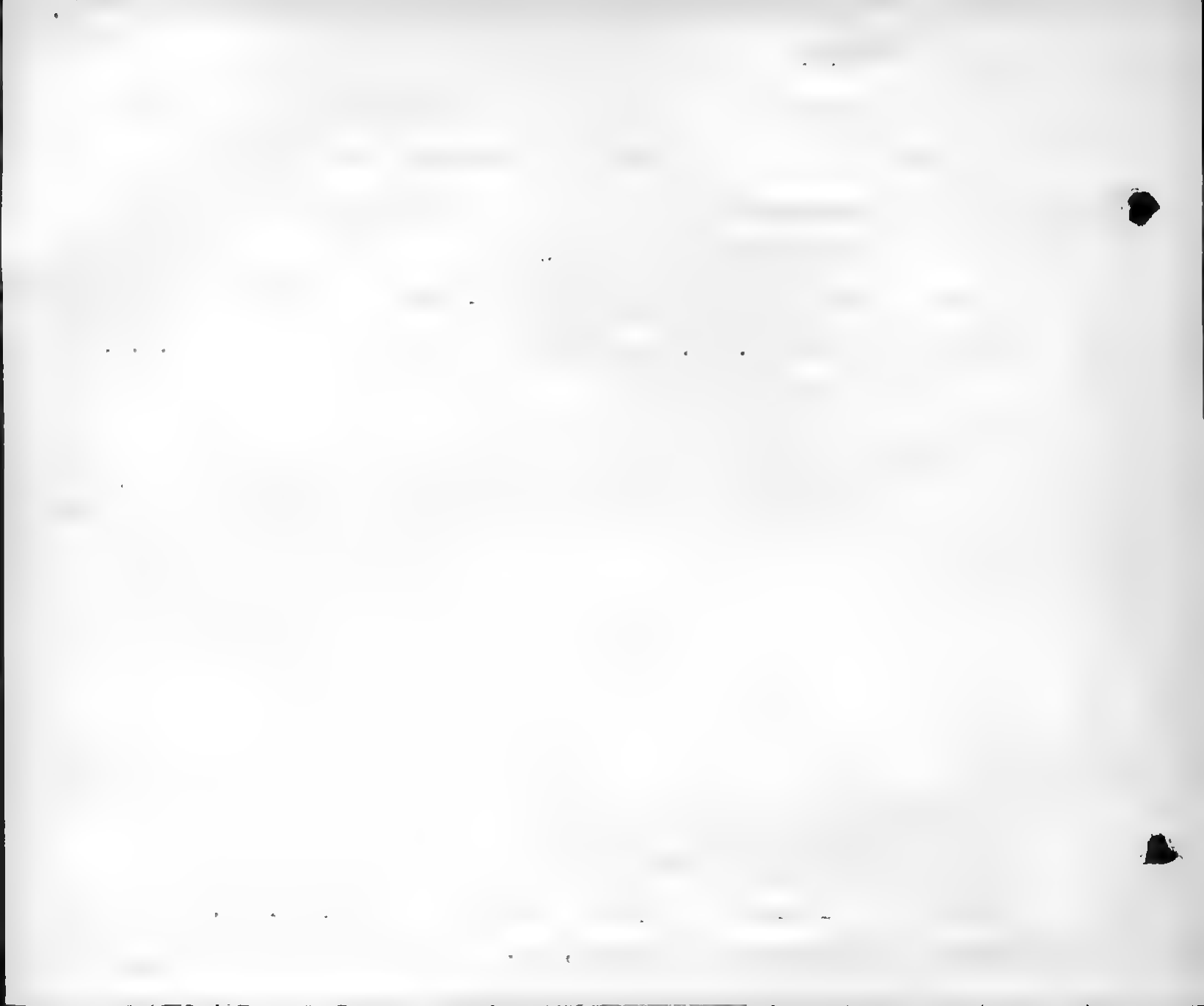
Reg. Dist. No.

09971

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
c. LENGTH OF STAY IN lb life		d. STREET ADDRESS Church Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Walter Middle Howard Last		4. DATE OF DEATH Month 9-10 Day Year 1960	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-14-1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Sanitation	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Howard	
14. MOTHER'S MAIDEN NAME Emma Perry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16 SOCIAL SECURITY NO none		INFORMANT Hilda Ford , Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JULY 1960 to SEPT 10 1960 that I last saw the deceased alive on SEPT 8 1960 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William A. Pillsbury M.D.		PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY TIMONUM MD. 7-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-60	22c. NAME OF CEMETERY OR CREMATORY Jessop Methodist	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson4, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '60	24b. REGISTRAR'S SIGNATURE Arthur P. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10012

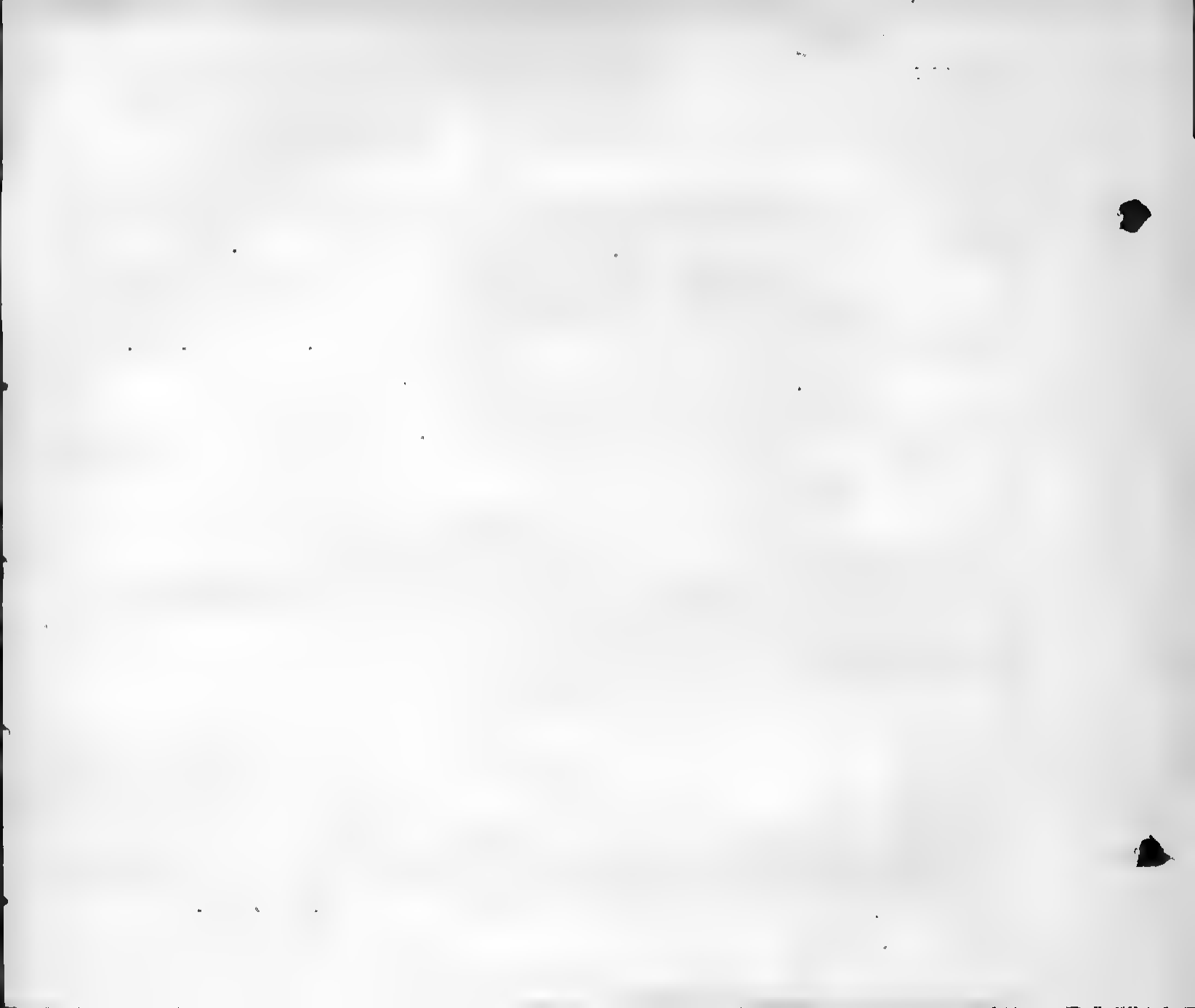
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillendale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillendale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6809 Collingsdale Road		e. STREET ADDRESS Zone 34 6809 Collingsdale Road	
3. NAME OF DECEASED (Type or print) First LENA Middle M. Last HUBBARD		4. DATE OF DEATH Month Sept. Day 9 Year 19 60	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1897
9. AGE (in years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Zink		14. MOTHER'S MAIDEN NAME Mary Noellert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT Catherine L. Carter, daughter, above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 1 SIX DUE TO generalized metastasis to abdominal organs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) to abdominal organs (c) to abdominal organs			INTERVAL BETWEEN ONSET AND DEATH 6 months to 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1956 to Sept 1960 that I last saw the deceased alive on Sept 9 19 60 , and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Smith M.D.		DATE SIGNED Sept 12 1960	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/60	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS Funeral Home 3331 Brehms Lane		24a. REC'D BY REGISTRAR SEP 13 '60	24b. REGISTRAR'S SIGNATURE John S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10013

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09973

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Wings Mills Md. c. LENGTH OF STAY IN 1b 1 yr. 2 mo.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24, Maryland	
3. NAME OF DECEASED (Type or print) First Marcella Middle Alice Last Hunt		4. DATE OF DEATH Month 9 Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-59
9. AGE (In years lost birthday) yrs 1		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 17 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Redmon Hunt		14. MOTHER'S MAIDEN NAME Grace Marcella Ruil Fritz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Rosewood Records		Address O'Wings Mills	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus unarkeel. 344 X DUE TO (b) complicated by aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) of stomach content			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 3-9 p. m. 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 60 (County) 9-17 (State) 60	
21. I certify that (I) (this hospital) attended the deceased from 3-9 to 9-17 that (I) (we) last saw the deceased alive on 9-17 19 60 and that death occurred at 6:20 AM, from the causes and on the date stated above.			
22a. SIGNATURE John W. Rieckert		22b. DATE 9-17-60	
22c. PHYSICIAN'S NAME (Type) John W. Rieckert		22d. ADDRESS 4307 Mainfield Ave Balt 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 21/60	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cem.		23d. LOCATION (City, town, or county) O'Wings Mills Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer, Son Rosewoodtown Md		25a. REC'D BY REGISTRAR SEP 23 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

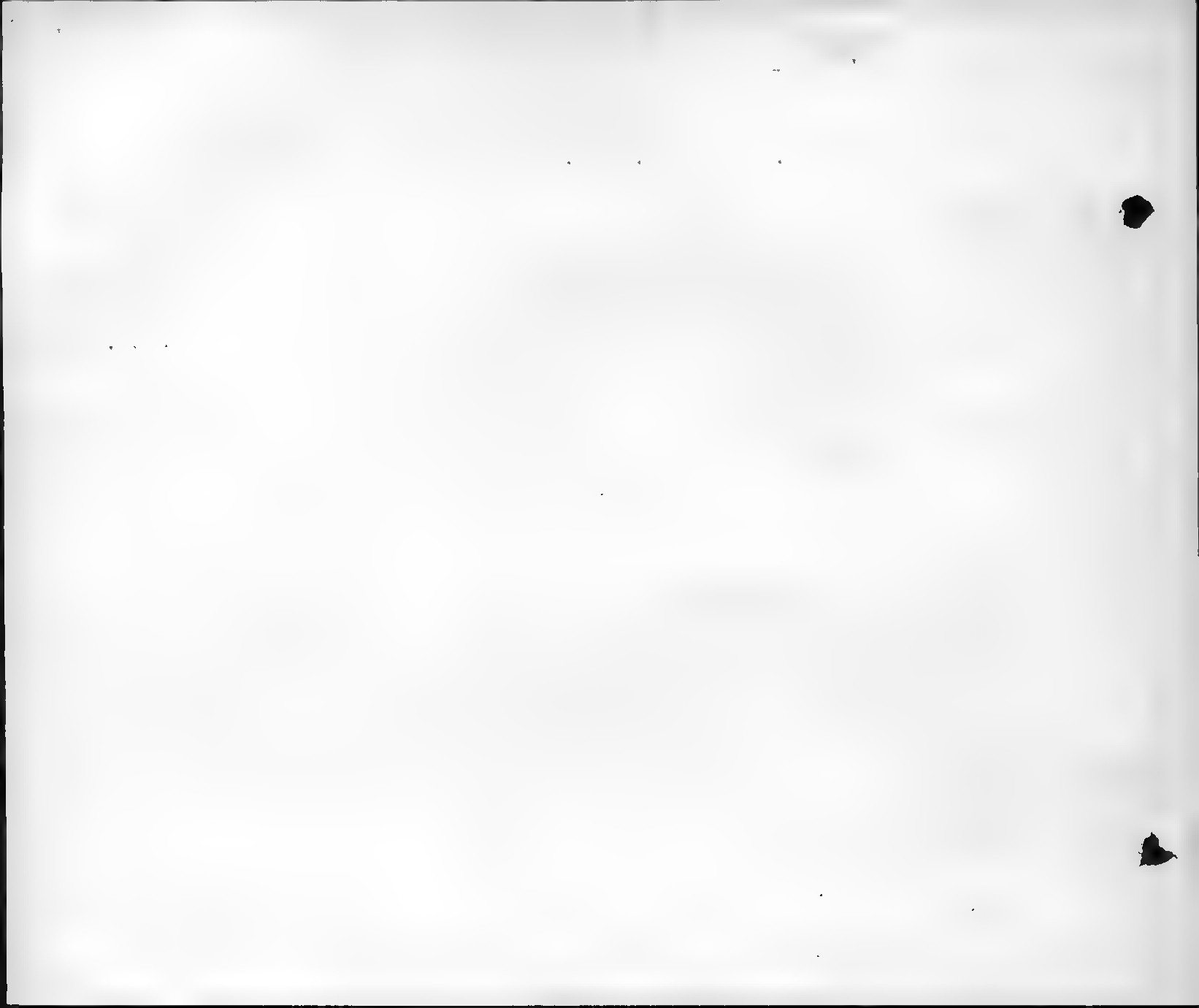
M

112

I

2

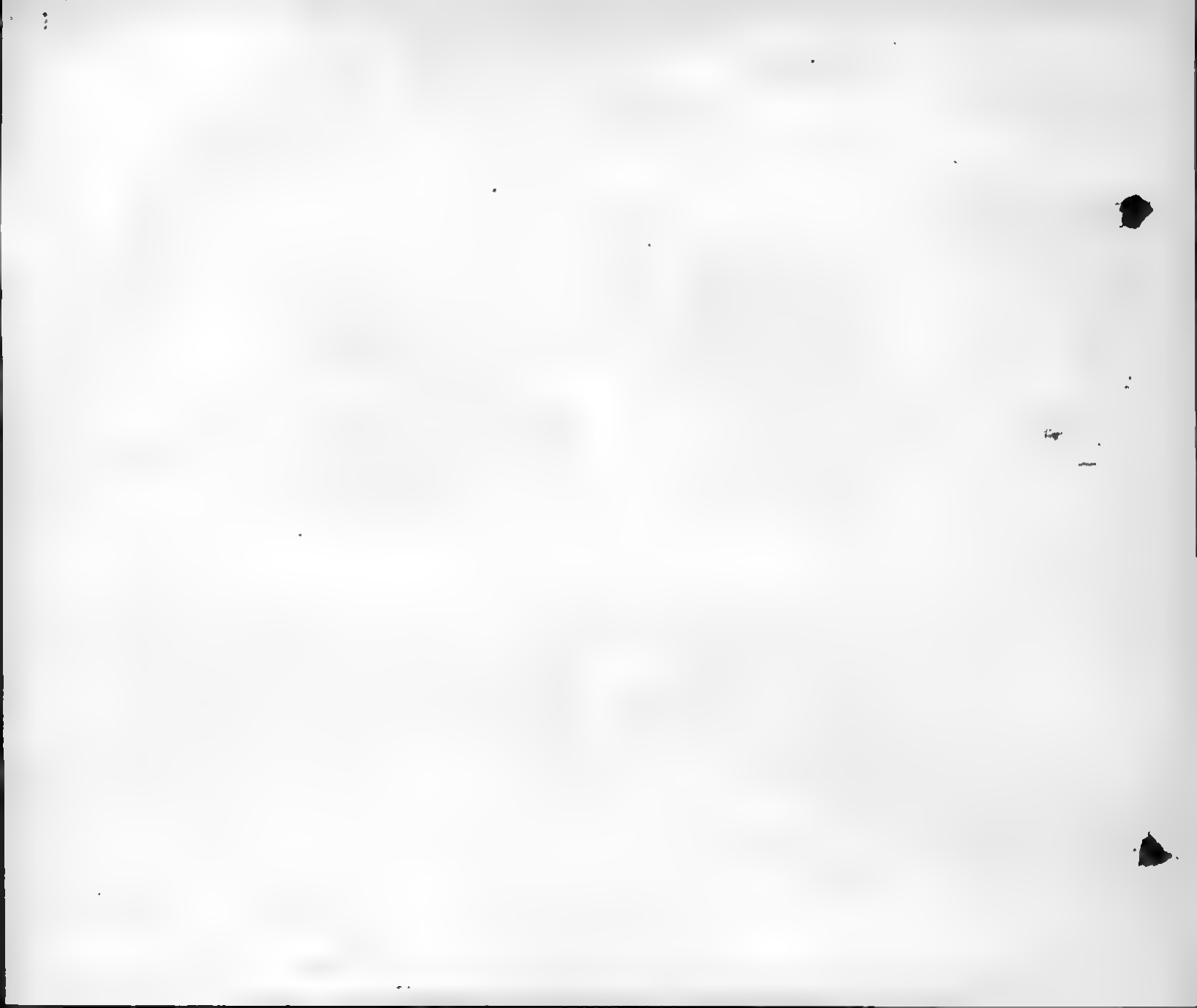
1



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
09974
10014
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. LENGTH OF STAY IN 1b <u>18 Mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hoppley Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cummings Mills</u>			
f. STREET ADDRESS <u>Chittenden Lane 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dr. Henry Talbott Hutchins</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1960</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb 3, 1877</u>	9. AGE (In years last b. day) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Prof.</u>		11 BIRTHPLACE (State or foreign country) <u>Mass</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>George F. Hutchins</u>				14. MOTHER'S MAIDEN NAME <u>Edna Fairbanks</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WW I</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>Mrs W. Barry Wood</u> Address <u>Cummings Mills Chittenden Lane</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO <u>arteriosclerosis, cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>53 IX</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>March 1, 1960</u> to <u>Sept 23, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 22, 1960</u> and that death occurred at <u>8 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Palmer F. R. Williams</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>PALMER F. R. Williams</u>				22d. ADDRESS <u>Pikesville 8. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				25a. REC'D BY REGISTRAR <u>SEP 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Jones</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

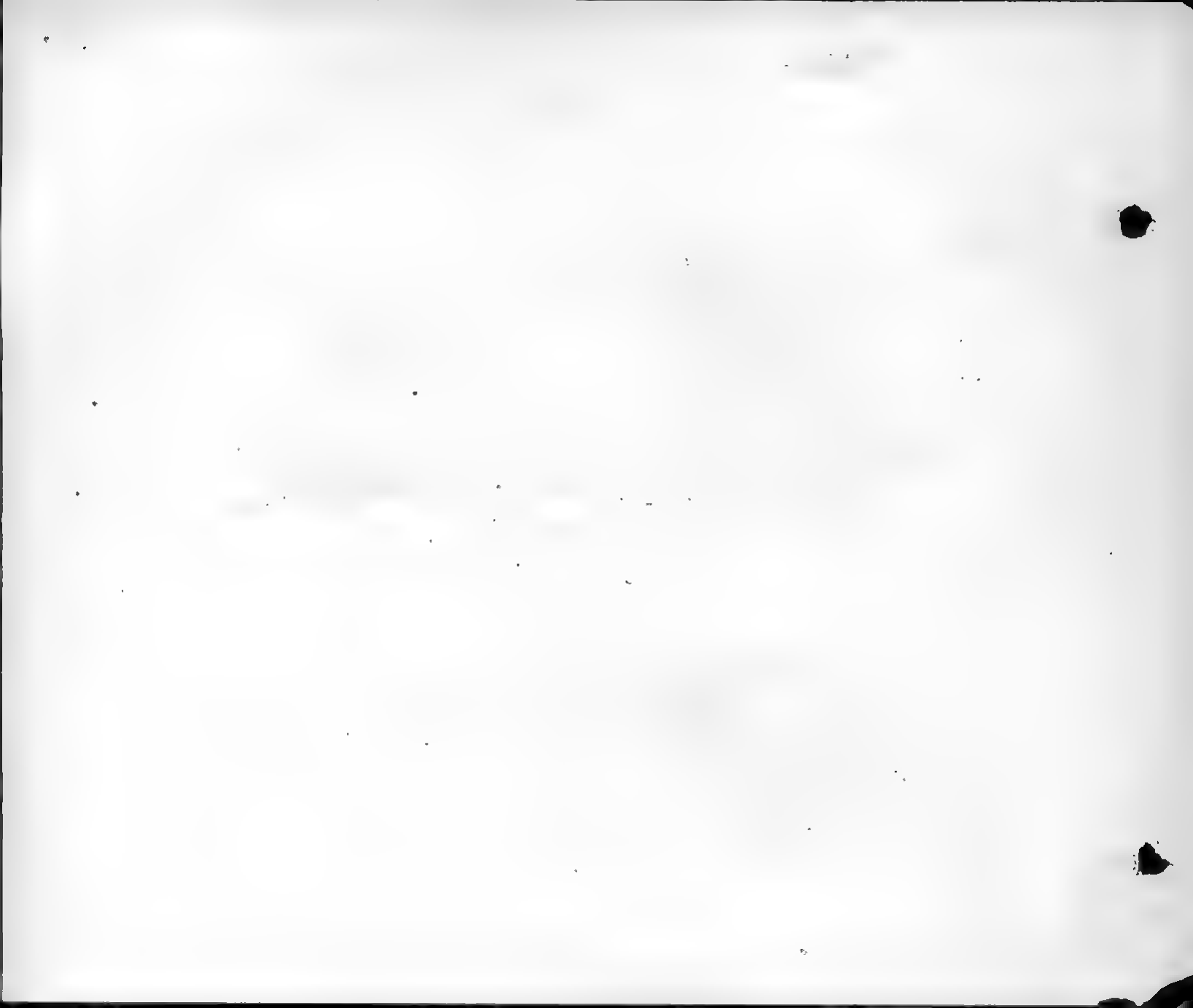
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. LENGTH OF STAY IN 1b <u>65 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ellen Psemock</u>		4. DATE OF DEATH Month Day Year <u>Sept 29 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9-1871</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Fork Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John. Hall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>70-</u>	
17. INFORMANT Address <u>Baldwin Md</u> <u>Mrs Clarence M. Harrison</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 593 X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Aphasia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>Sept 26 1960</u> that I last saw the deceased alive on <u>Sept 26 1960</u> , and that death occurred at <u>Md</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Walter M. Hammett, Baldwin</u>			
PHYSICIAN'S NAME (Type) <u>Walter M. Hammett, Baldwin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>Oct 1-60</u>	<u>Fork</u>	<u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter M. Hammett, Baldwin</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10016

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09976

1. PLACE OF DEATH COUNTY Baltimore STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c LENGTH OF STAY IN 1b 48 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d STREET ADDRESS 210 Warfield Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last JACKSON		4. DATE OF DEATH Month September Day 12 Year 1960	
5 SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1877
9 AGE (n years last birthday) yrs 82		IF UNDER 1 YEAR Months Days F UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Gospel	
11. BIRTHPLACE (State or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas J. Jackson		14. MOTHER'S MAIDEN NAME Lanita Hollis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 5/8/00-11/28/02		16. SOCIAL SECURITY NO. 3/8/00-11/28/02	
17. INFORMANT Clin. Rec., Vet. Hospital, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE WITH METASTASES TO PELVIC BONES, LIVER AND LUNGS Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) EMPHYSEMA OF LUNGS (c) CACHEXIA		INTERVAL BETWEEN ONSET AND DEATH 4 YEARS UNKNOWN 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 26 1960 to Sept. 12 1960 , that (we) last saw the deceased alive on Sept. 12 1960 , and that death occurred at 6:30 A M, from the causes and on the date stated above			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE 9/12/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-16-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 2004 Orleans St. Balto. Md.		25a. REC'D. BY REGISTRAR SEP 22 1960	
25b. REGISTRAR'S SIGNATURE Wm. S. Hanna			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10017

CERTIFICATE OF DEATH

Reg. Dist. No.

09977

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Cockeysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Powers Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Henry</i> Last <i>Johnson Sr</i>		4. DATE OF DEATH Month <i>September</i> Day <i>1</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OF RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>31 August 1892</i>
9. AGE (In years last birthday) <i>78</i> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labour</i>	
11. BIRTHPLACE (State or foreign country) <i>Sweet Air Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Ida Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-26-2556A</i>	
17. INFORMANT <i>Son</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of prostate</i> DUE TO (b) <i></i> DUE TO (c) <i></i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i></i> a. m. <i></i> p. m. <i></i> 19 <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 19, 56</i> to <i>Sept 1, 1960</i> , that I last saw the deceased alive on <i>Sept 1, 1960</i> , and that death occurred at <i>10:35 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, State) <i>Cockeysville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		DATE SIGNED <i>Sept 19 60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-4-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Basil Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Hender</i>		ADDRESS <i>501 W. Biddle St.</i>	
24a. REC'D BY REGISTRAR <i>SEP 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>O. Stuart S. Evans</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

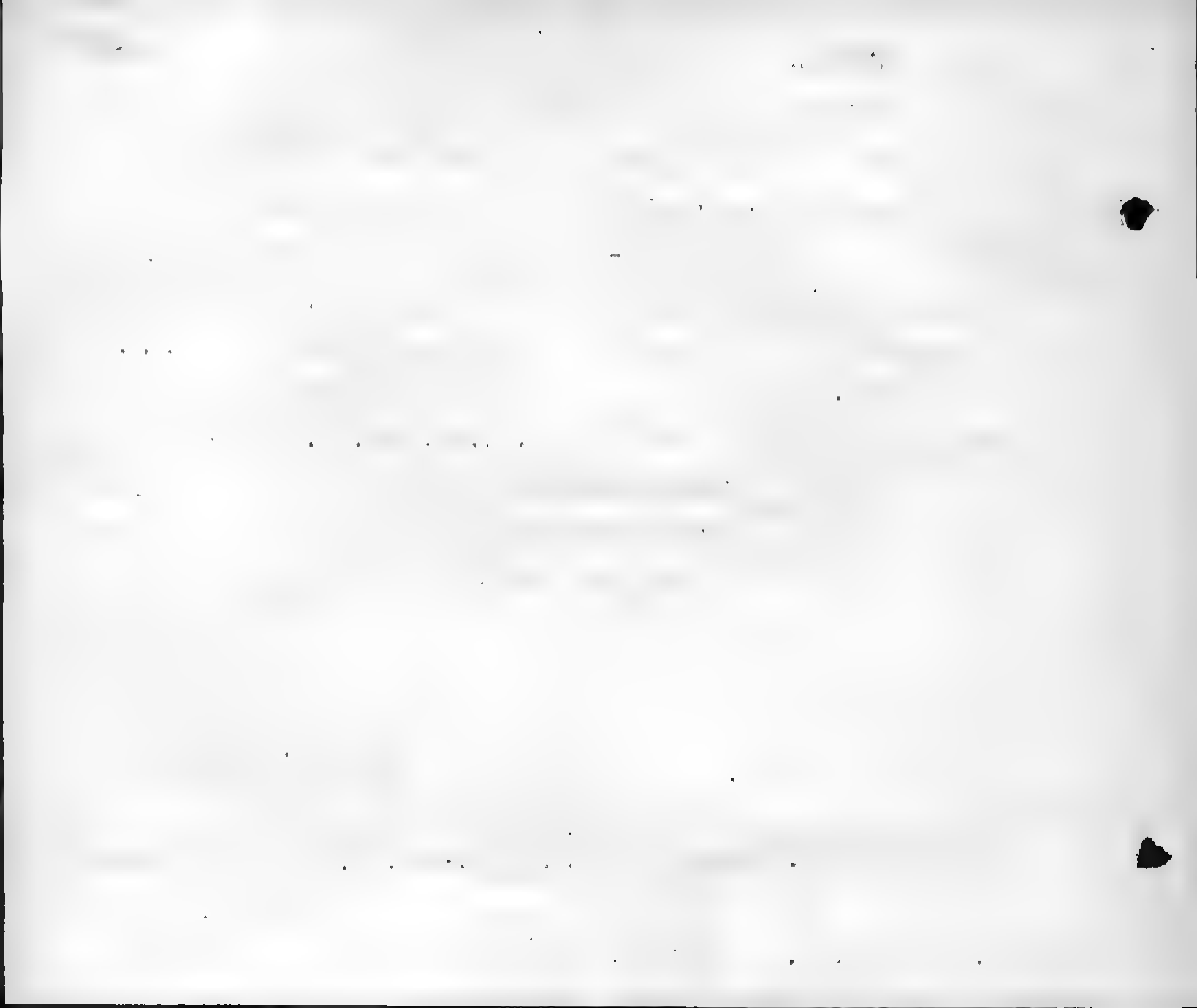
10018

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09978

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c LENGTH OF STAY IN 1b 28 Days			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 101 Kingston Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle - Last JOHNSON				4. DATE OF DEATH Month SEPTEMBER Day 3 Year 1960			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8/1/83	
9 AGE (In years lost birthday) 77 yrs		F UNDER 1 YEAR Months 8 Days 15 Hours 45 Min 00		IF UNDER 24 HRS Hours 45 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11 BIRTHPLACE (State or foreign country) Mapleton, Michigan		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Johnson				14 MOTHER'S MAIDEN NAME Carolina Fredrickson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I & WW II		17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CHRONIC PANCREATITIS (c) OLD MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (if (this hospital) attended the deceased from August 6, 1960 to Sept. 3, 1960 , that (i) (we) last saw the deceased alive on Sept. 3, 1960 , and that death occurred at 7:45 AM on the causes and on the date stated above							
22a. SIGNATURE Joseph L. Reeves M.D.		22b. DATE SIGNED 9/4/60		22c. PHYSICIAN'S NAME Type JOSEPH L. REEVES		22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR 6009 Harford Road Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION



may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

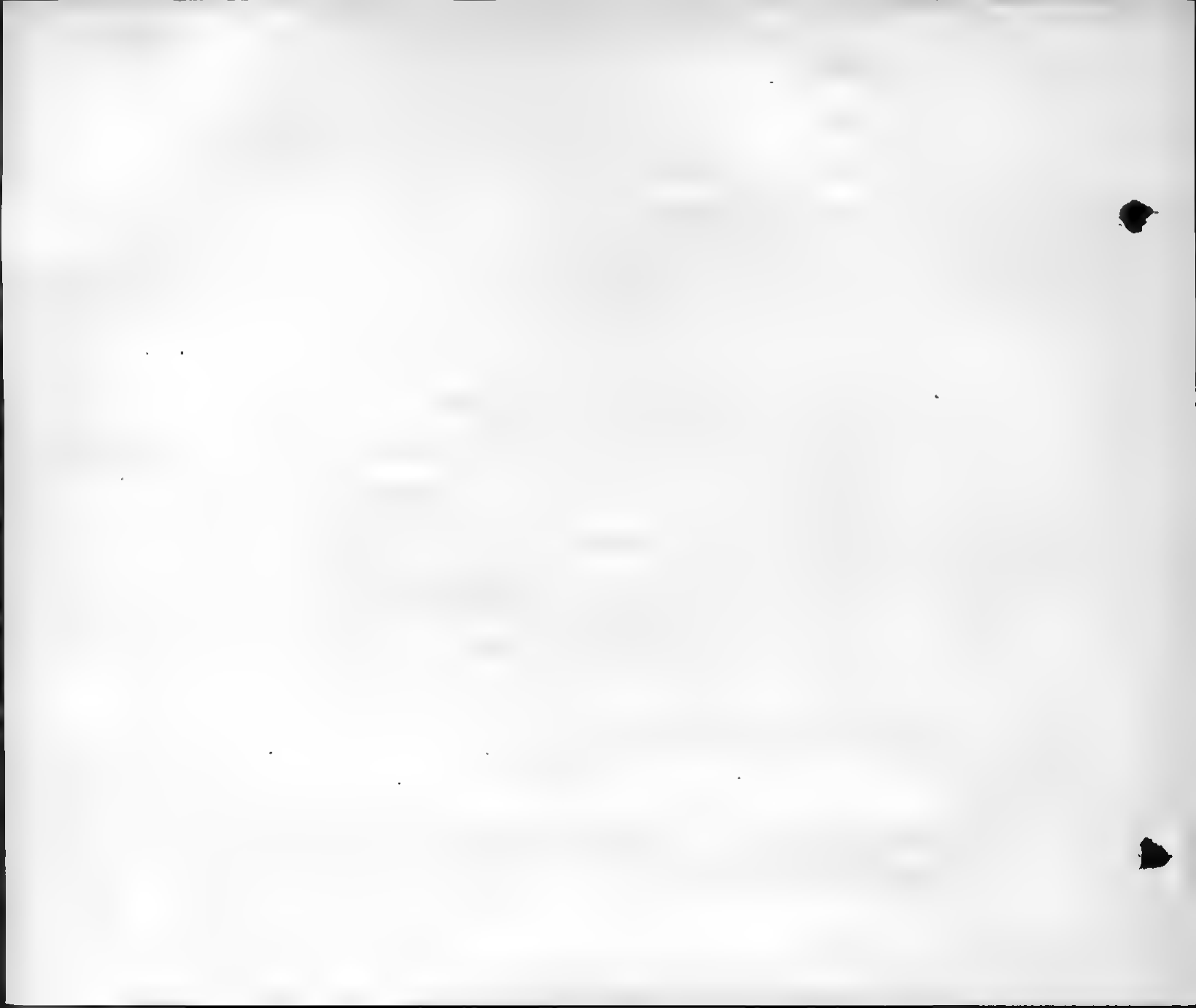
09979

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 38yrl4days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hugh Middle Andrew Last Jones				4. DATE OF DEATH Month September Day 29 Year 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1893		9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67	IF UNDER 24 HRS Months 67 Days 67 Hours 67 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hugh E. Jones				14. MOTHER'S MAIDEN NAME Edith F. Boyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia and Bilateral hydronephrosis DUE TO (b) Urinary retention Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) Carcinoma of the prostate						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1960 to Sept. 29, 1960 , that (I) (we) last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 2:00 p. M. from the causes and on the date stated above							
22a. SIGNATURE Stella Wachslar M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 9-29-60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Oct. 30, 1960		23c. NAME OF CEMETERY OR CREMATORY DARLINGTON, MD.		23d. LOCATION (City, town, or county) (State) DARLINGTON MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Harker				25a. REC'D BY REGISTRAR Oct 3 '60		25b. REGISTRAR'S SIGNATURE D. L. S. Kenna	

1

S14

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1002

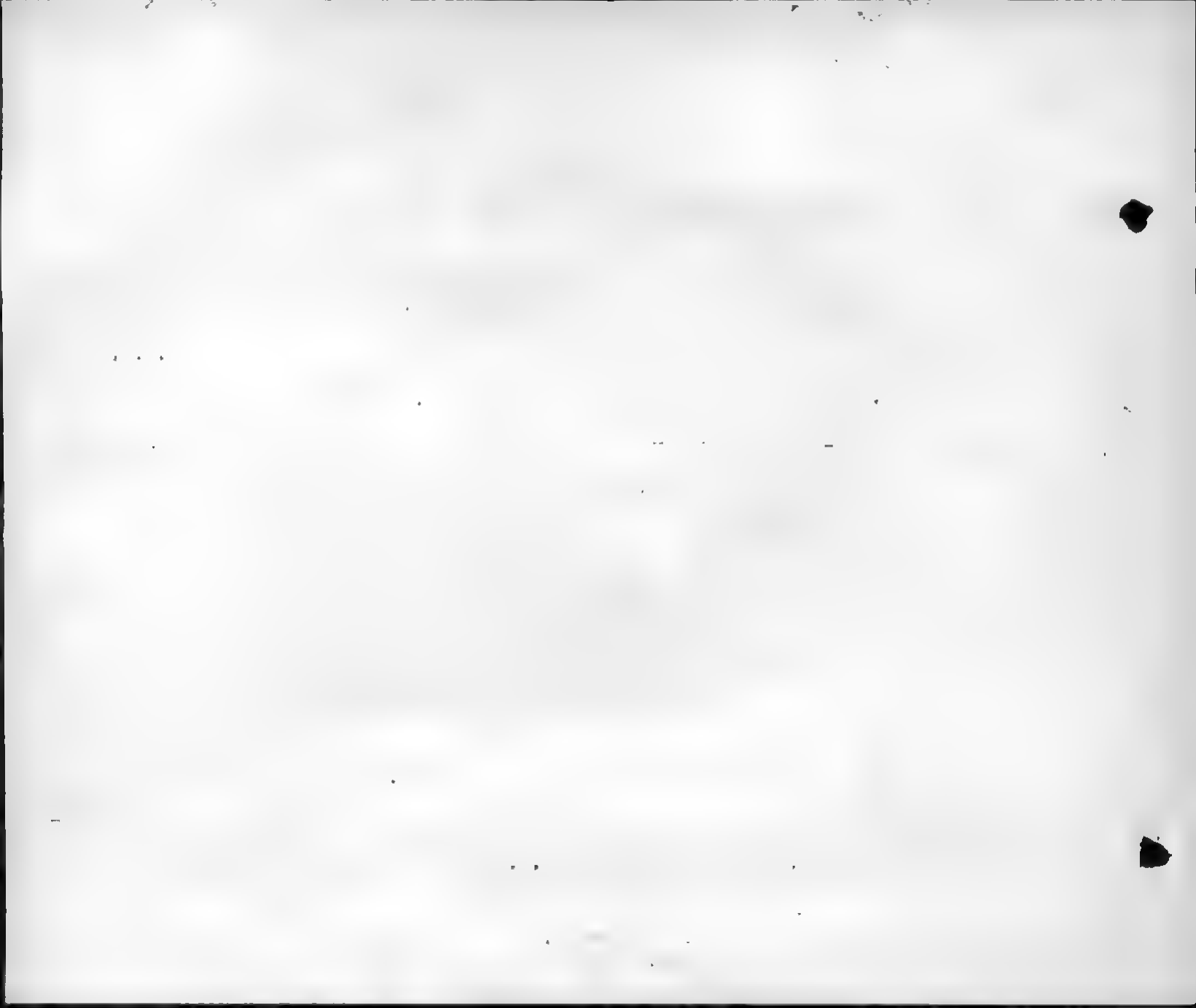
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09980

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 50 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 730 LIGHT STREET			
3. NAME OF DECEASED (Type or print) First THOMAS Middle E Last KANE				4. DATE OF DEATH Month September Day 24 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 21, 1890	
9. AGE (In years lost birthday) 69 yrs		10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK J. KANE				14. MOTHER'S MAIDEN NAME MARY G. DOUGHERTY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO 218-09-9154		17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA AND (OBSTRUCTIVE JAUNDICE) HEPATIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost COMA CARCINOMA OF PANCREAS						INTERVAL BETWEEN ONSET AND DEATH 48 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from August 5, 1960 to September 24, 1960 , that X (we) last saw the deceased alive on September 24, 1960 , and that death occurred on September 24, 1960 at 6:45 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Ernest O. Brown				22b. DATE SIGNED 9-24-60			
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN				22d. ADDRESS M.D. VAH BALTO MD - FT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 27/60		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE KRAUSE FUNERAL HOME				25a. REC'D BY REGISTRAR SEP 27 '60		25b. REGISTRAR'S SIGNATURE W. S. F...	

M

1



10021

CERTIFICATE OF DEATH

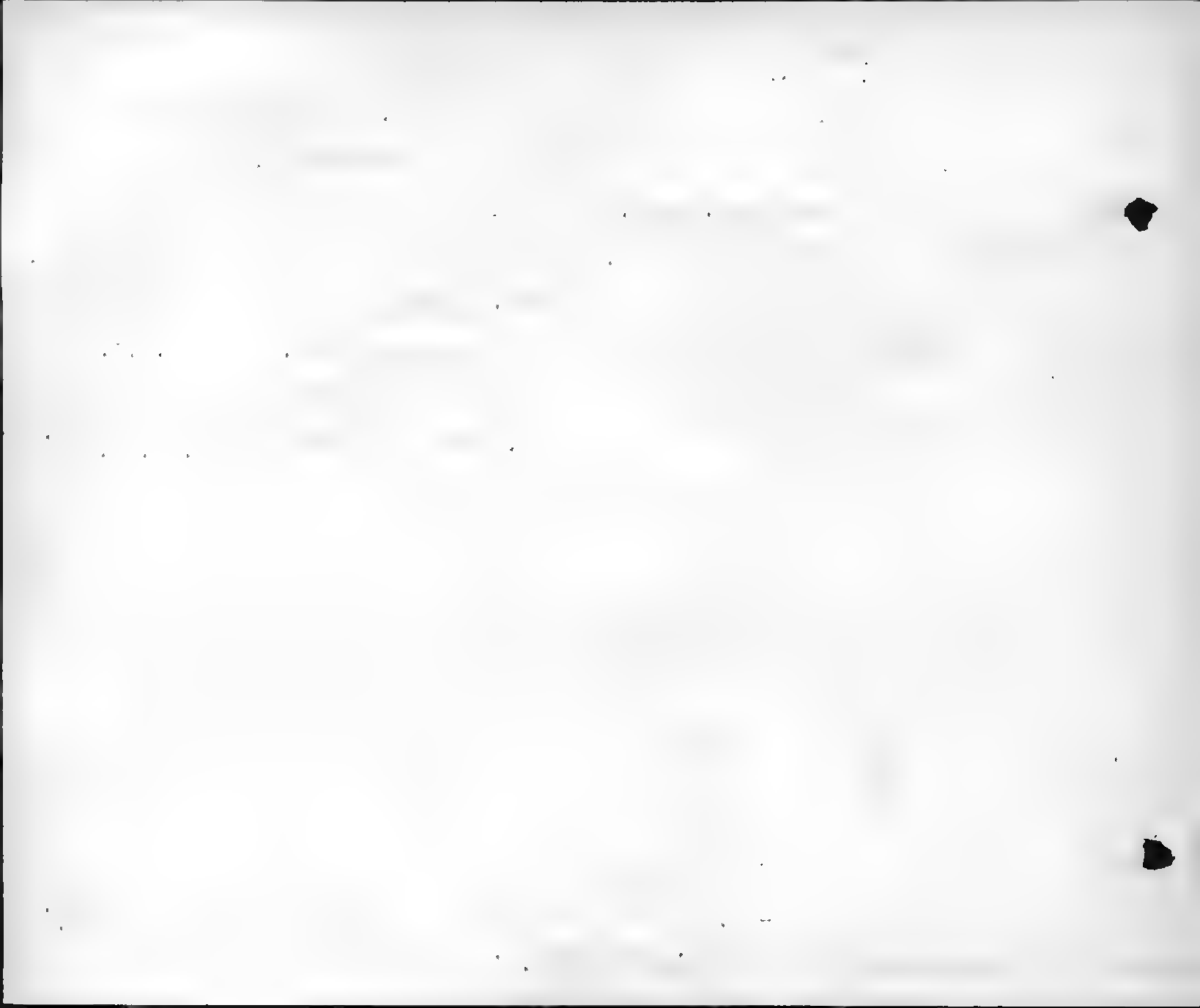
09981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 6,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Lodge Conv. Home.		d. STREET ADDRESS 3716 Eastwood Drive	
3. NAME OF DECEASED (Type or print) First AMELIA Middle V. Last KAVANAUGH		4. DATE OF DEATH Month Sept. Day 18, Year 1960.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? Conner	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Chas. Edward Kavanaugh		17. INFORMANT 9103 Yvonne Ave. Balto., 6, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Senescent Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary of Colon. DUE TO ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 13 , 19 60 , to Sept. 18 , 19 60 , that I last saw the deceased alive on Sept. 17 , 19 60 , and that death occurred at 3:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 520 D St. Balto. Md.	
PHYSICIAN'S NAME (Type) James T. Means		DATE SIGNED 9-19-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-21-60.	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) 3310 Taylor Ave. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeller		24a. REC'D BY REGISTRAR SEP 21 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Zeller		24c. REGISTRAR'S SIGNATURE Charles S. Zeller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10022

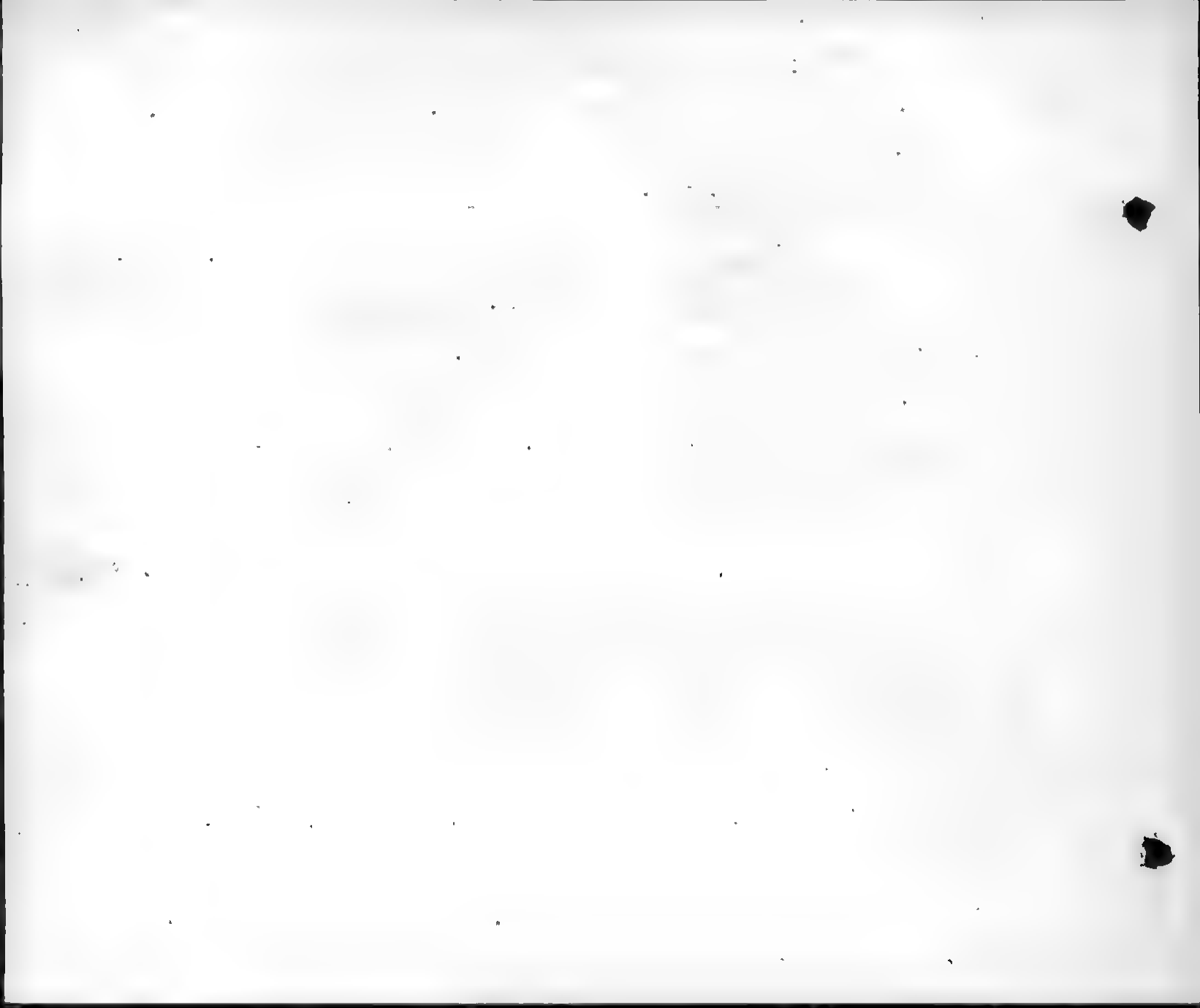
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6011 Campfield Rd. Augsburg Lutheran Home-		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle KELLEY Last KELLEY		4. DATE OF DEATH Month Sept. Day 17, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1878
9. AGE (In years last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Kelley		14. MOTHER'S MAIDEN NAME Pauline Muhl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Address Mr. Theodore W. Katenkamp-Augsburg Lutheran H			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Cerebral infarction DUE TO (2) - Broncho-Pneumonia DUE TO (3) - Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - Generalized Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 16 days 4 days 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 1958 to Sept. 17, 1960 that I last saw the deceased alive on Sept. 16, 1960 and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty Hts Balto. Md DATE SIGNED 9/17/60 ACTUAL SIGNATURE Earl L. Chambers M.D. PHYSICIAN'S NAME (Type) Earl L. Chambers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/60	22c. NAME OF CEMETERY OR CREMATORY Dryd Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner		24a. REC'D BY REGISTRAR DATE 19 60	24b. REGISTRAR'S SIGNATURE G. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10023

CERTIFICATE OF DEATH

09983

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 21 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (24) d. STREET ADDRESS 3714 East Lombard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle P. Last KELLY				4. DATE OF DEATH Month September Day 21 Year 19 60			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 13, 1910	
9 AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min 50		IF UNDER 24 HRS Months 50 Days 50 Hours 50 Min 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Park System		11 BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John J. Kelly				14. MOTHER'S MAIDEN NAME Mary A. Keavney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service, WW II)				16. SOCIAL SECURITY NO 218-14-7897		17. INFORMANT Clinical Rec. VAH, Balto. 18, Md. FT. HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT MIDDLE LOBE WITH METASTASES TO LYMPH NODES, LIVER, HEART, PANCREAS, BOTH ADRENALS, RIGHT KIDNEY AND LEFT 5TH RIB Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) EDEMA OF THE LUNGS (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 6 HOURS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (this hospital) attended the deceased from August 31, 1960 to September 21, 1960 , that (we) last saw the deceased alive on 9/21/60 19 and that death occurred at 8:15 A. M. from the causes and on the date stated above							
22a. SIGNATURE Fredrick S. Donaldson M.D.				22b. DATE 9/21/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins				25a. REC'D BY REGISTRAR SEP 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for use as the burial-transit permit.

Page 4

death

and

filled with

and

many

event

within

72

hours

after

death.

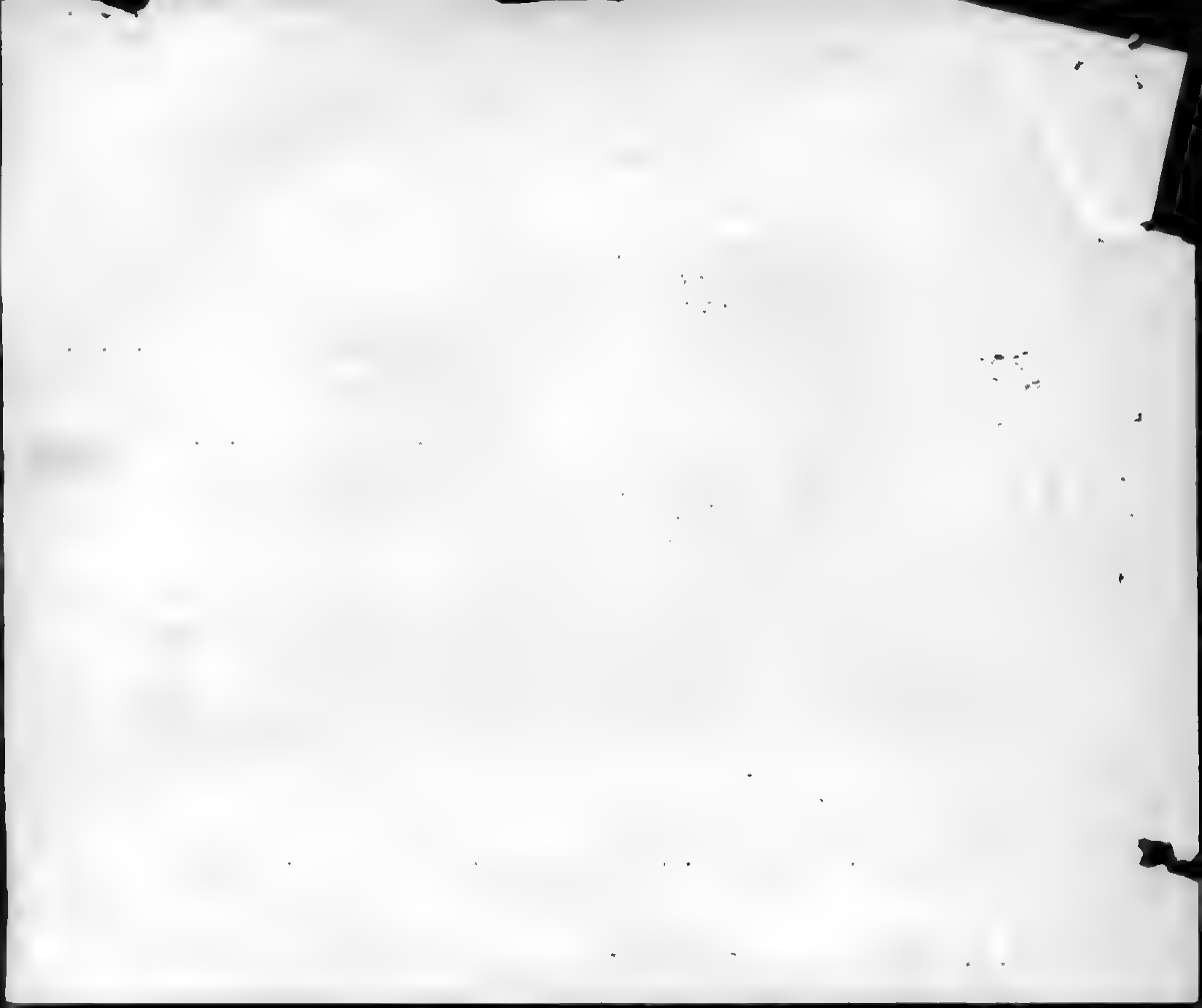
the

State

Board

of

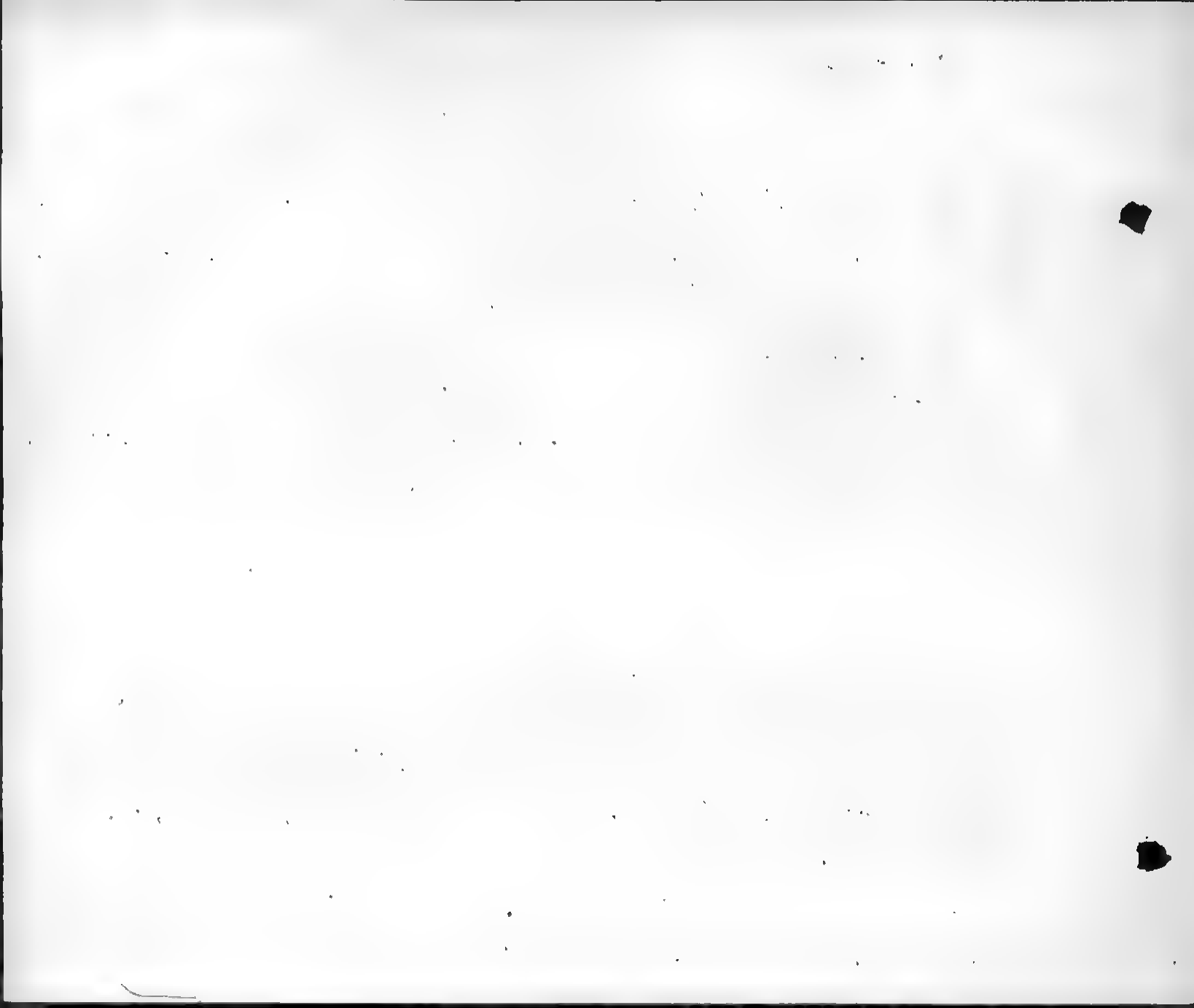
Health



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>548 Valley View Avenue</i>		d. STREET ADDRESS <i>548 Valley View Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Charles H. Kirchner</i>		4. DATE OF DEATH Month Day Year <i>September 17, 1960</i>	
5 SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 28, 1901</i>
9. AGE (in years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Poultry Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Kirchner</i>		14. MOTHER'S MAIDEN NAME <i>Caroline</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Mrs. Lily Kirchner 548 Valley View Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lymphom Sarcoma of Mediastinum</i> 200-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <i>None 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 26</i> , 1960, to <i>Sept. 17</i> , 1960, that I last saw the deceased alive on <i>Sept. 16</i> , 1960, and that death occurred at <i>5:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. S. Chalfart</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>6210 York Road, Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Dr. A. S. Chalfart</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/20/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 20 '60</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09985

Reg. Dist. No.

110025

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 121		c. LENGTH OF STAY IN 1b - 121		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (-12)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6467 Blenheim				d. STREET ADDRESS 6467 Blenheim Road			
3. NAME OF DECEASED (Type or print) First LOUISE Middle KNOCHE Last KNOCHE				4. DATE OF DEATH Month 9 Day 4 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1885	
9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75		IF UNDER 24 HRS. Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Louis Scheide				14. MOTHER'S MAIDEN NAME Louise Pensel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Vernone Scheide Address 2100 Lake Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive and ARTERIOSELEROTIC Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. S. FISHER				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. S. FISHER				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				9/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Road #14				24a. REC'D BY REGISTRAR SEP 9 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1912

1912

1912

1912

1912

1912

1912

1912

10026

CERTIFICATE OF DEATH

Reg. Dist. No.

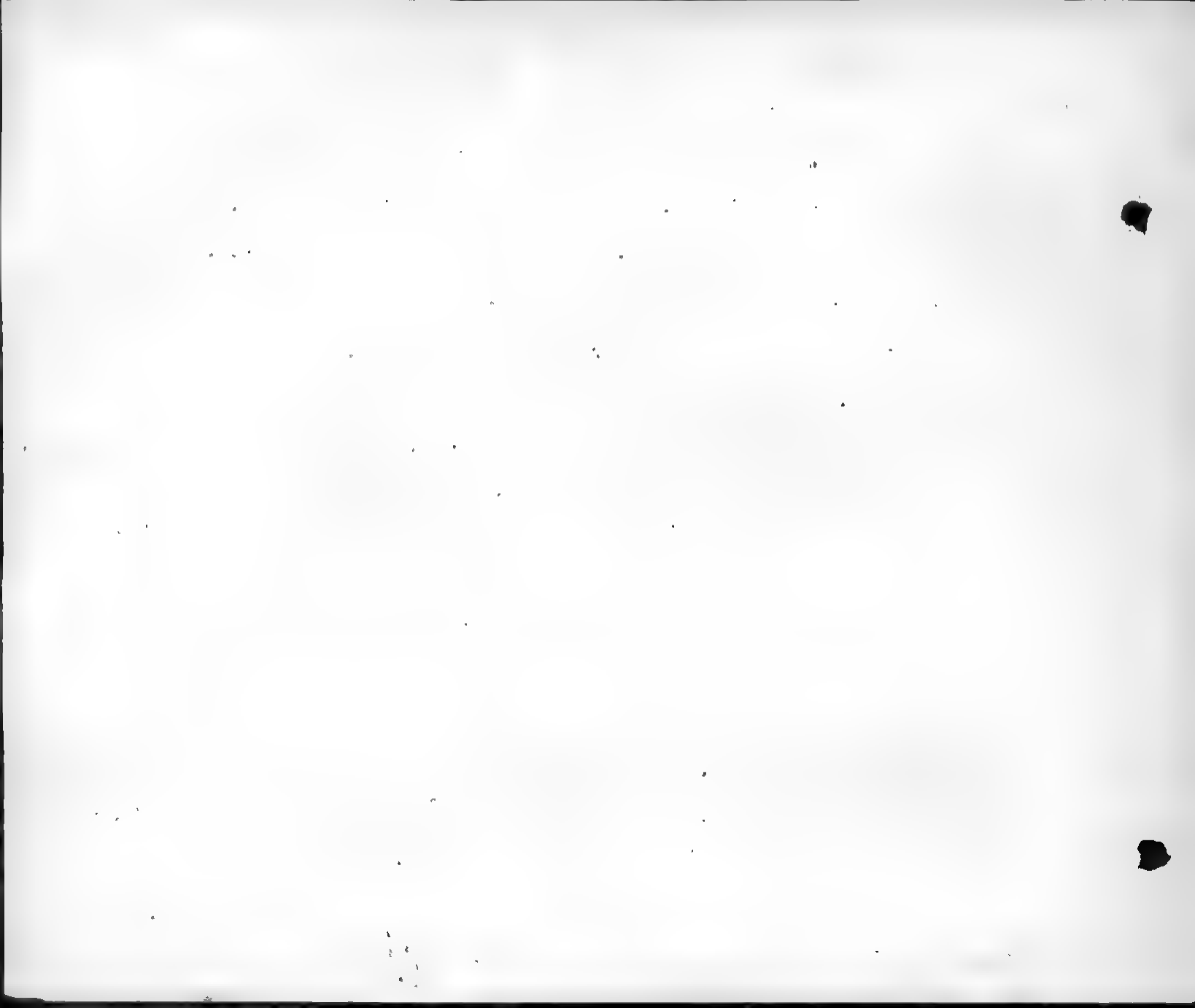
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>707 Stemmers Run Rd.</u>		d. STREET ADDRESS <u>707 Stemmers Run Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>E.</u> Last <u>Kollock</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Y. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Pryor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Miss Elizabeth B. Kollock</u>		Address <u>707 Stemmers Run Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sclerotic arteriosclerosis</u> DUE TO H.C.V.D. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Less than 5 days</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>med.</u> 19 <u>54</u> , to <u>9/22</u> 19 <u>60</u> , that I last saw the deceased alive on <u>9/21</u> 19 <u>60</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Platt</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>	
PHYSICIAN'S NAME (Type) <u>J. PLATT, M.D.</u>		DATE SIGNED <u>9/23/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-24-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00987

Reg. Dist. No.

9952

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown,</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster R.D.6</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. M. E. Strobel's office</u>				d. STREET ADDRESS <u>Klees Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Kathleen</u> Middle <u>Carol</u> Last <u>Koons</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1960</u>		
9. AGE (In years last birthday) <u>6 weeks</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Kenneth C. Koons</u>				14. MOTHER'S MAIDEN NAME <u>Jacqueline Miller</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Kenneth C. Koons, Westminster, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>925.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child got face buried in plastic bag.</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:10 a.m. 9-13-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Westminster, Carroll, Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>		

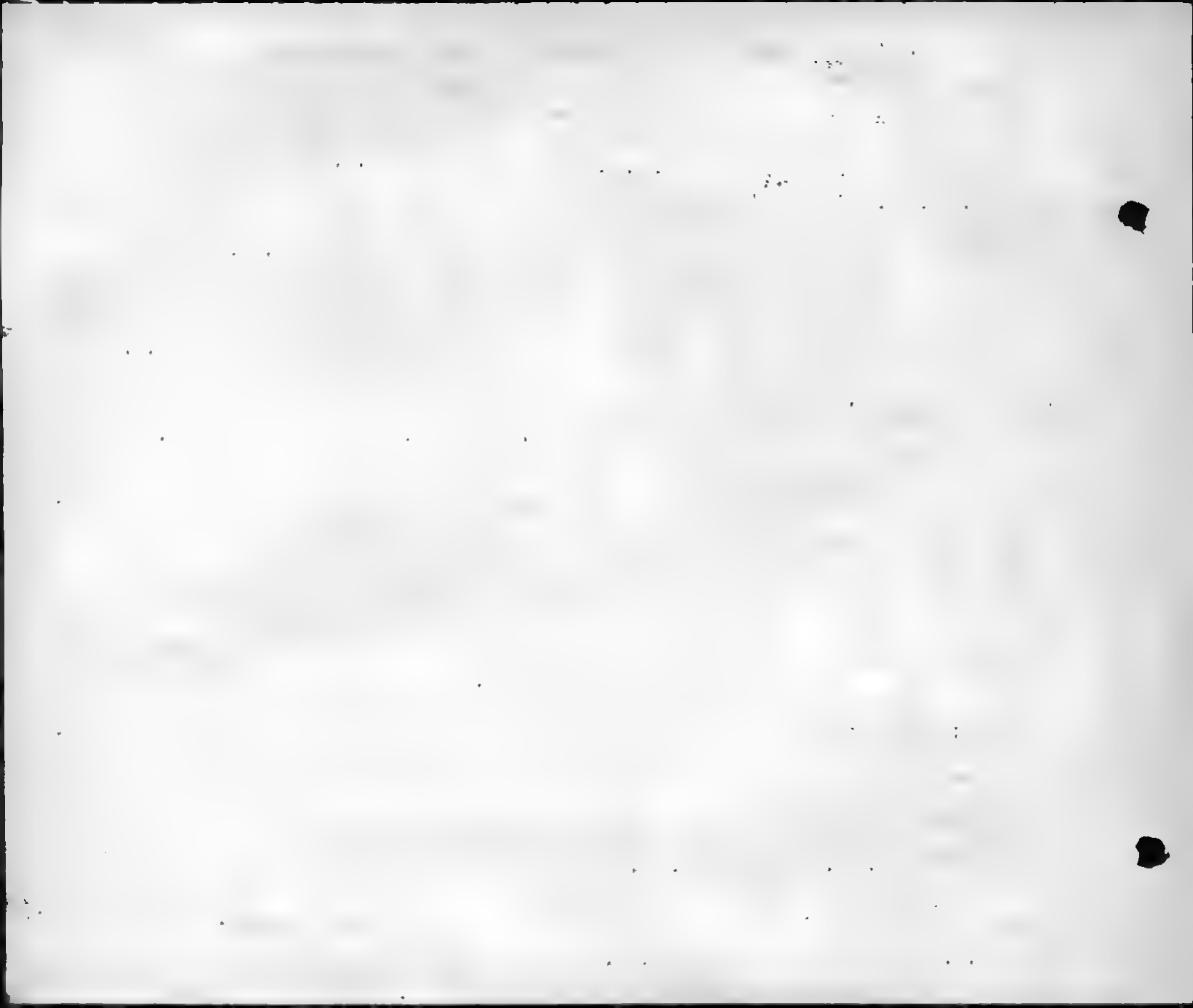
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope, with the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

VS. A15ME(5)

SM 9/55

16000

27 27 X 6



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

FOR STATE
HEALTH DEPT.

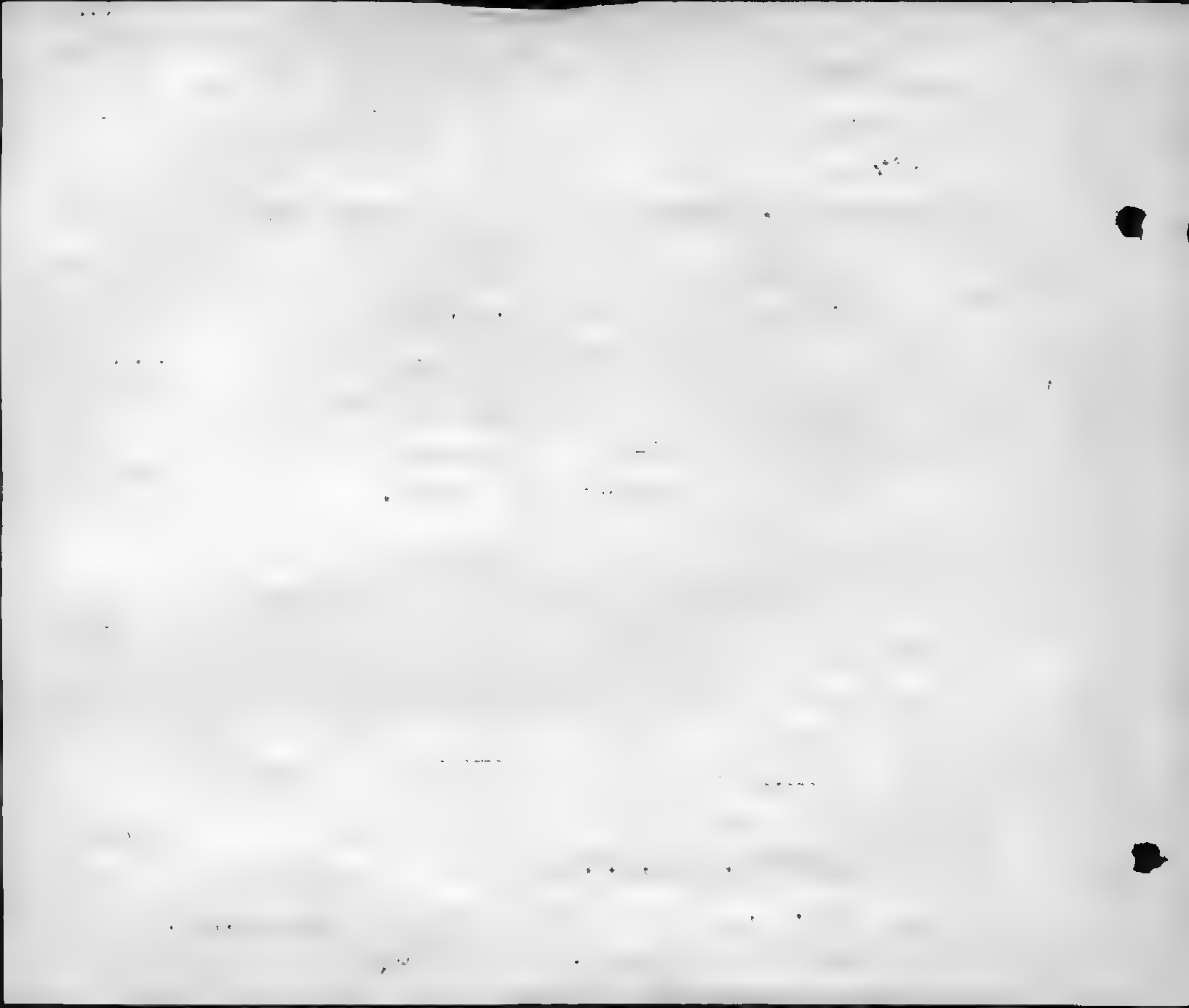
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09988

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Co. Dispensary		d. STREET ADDRESS 314 Maple Avenue	
3. NAME OF DECEASED (Type or print) ALFRED Karl KULECK		4. DATE OF DEATH September 16 19 60	
5. SEX Male 6. COLOR OR RACE White		8. DATE OF BIRTH Dec. 25, 1915	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 44 yrs. 14 mos. 14 days 14 hrs. 14 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Kuleck		14. MOTHER'S MAIDEN NAME Anna Schlessner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Will		16. SOCIAL SECURITY NO. 203-01-6303	
17. INFORMANT Helen Kuleck		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/17/60	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR James Bruzdinski ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR SEP 20 '60	
24b. REGISTRAR'S SIGNATURE Calvin S. Kraw			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then the certificate should be removed from the pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, within any event within 72 hours after death.

VR ATS (4)
15M 9/59

10028

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09989

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>English Consul</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3505 Shenandoah Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>St.</u> Last <u>Lamb Jr.</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/1945</u>
9. AGE (In years last birthday) <u>14</u> yrs		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Invalid</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Highlands N S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Homer St. Lamb Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Selma Turnmire</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT Address <u>Mrs Homer St. Lamb Sr. Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - Terminal - 3 days -</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental Retardation</u>			
(c) <u>Mal. development</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>14 years</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>45</u> to <u>9/27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>60</u> , and that death occurred at <u>8</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>Paul Schenfeld</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Paul Schenfeld</u>		22d. ADDRESS <u>2301 Annapolis Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>		25a. REC'D BY REG STRAR DATE <u>SEP 29 '60</u>	
ADDRESS <u>Rollins St.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



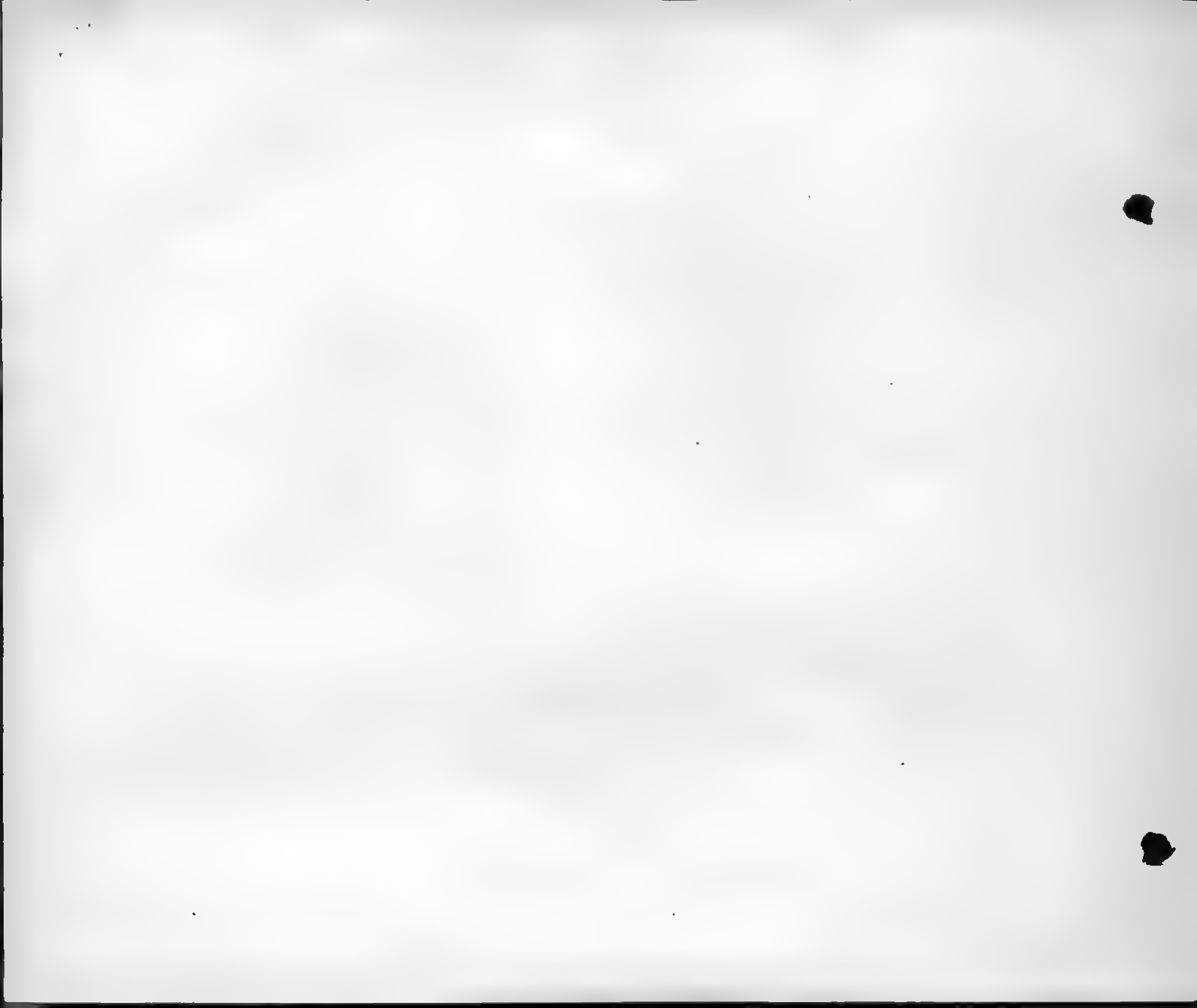
10029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Perry Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9822 Richlyn Dr.</u>		e. STREET ADDRESS <u>19822 Richlyn Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>T.</u> Last <u>Lange</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mending Sewing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218099808A</u>	
17. INFORMANT <u>Mary J. Dudley</u>		Address <u>9822 Richlyn Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>After severe Cardio Vascular Disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>27 Sept. 1960</u> , that I last saw the deceased alive on <u>23rd Sept. 1960</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7527 Belair Rd</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN C. HYLE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 30 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL PARK</u>		22d. LOCATION (City, town or county) (State) <u>TAYLOR AVE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. B. 7110 BELAIR RD.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

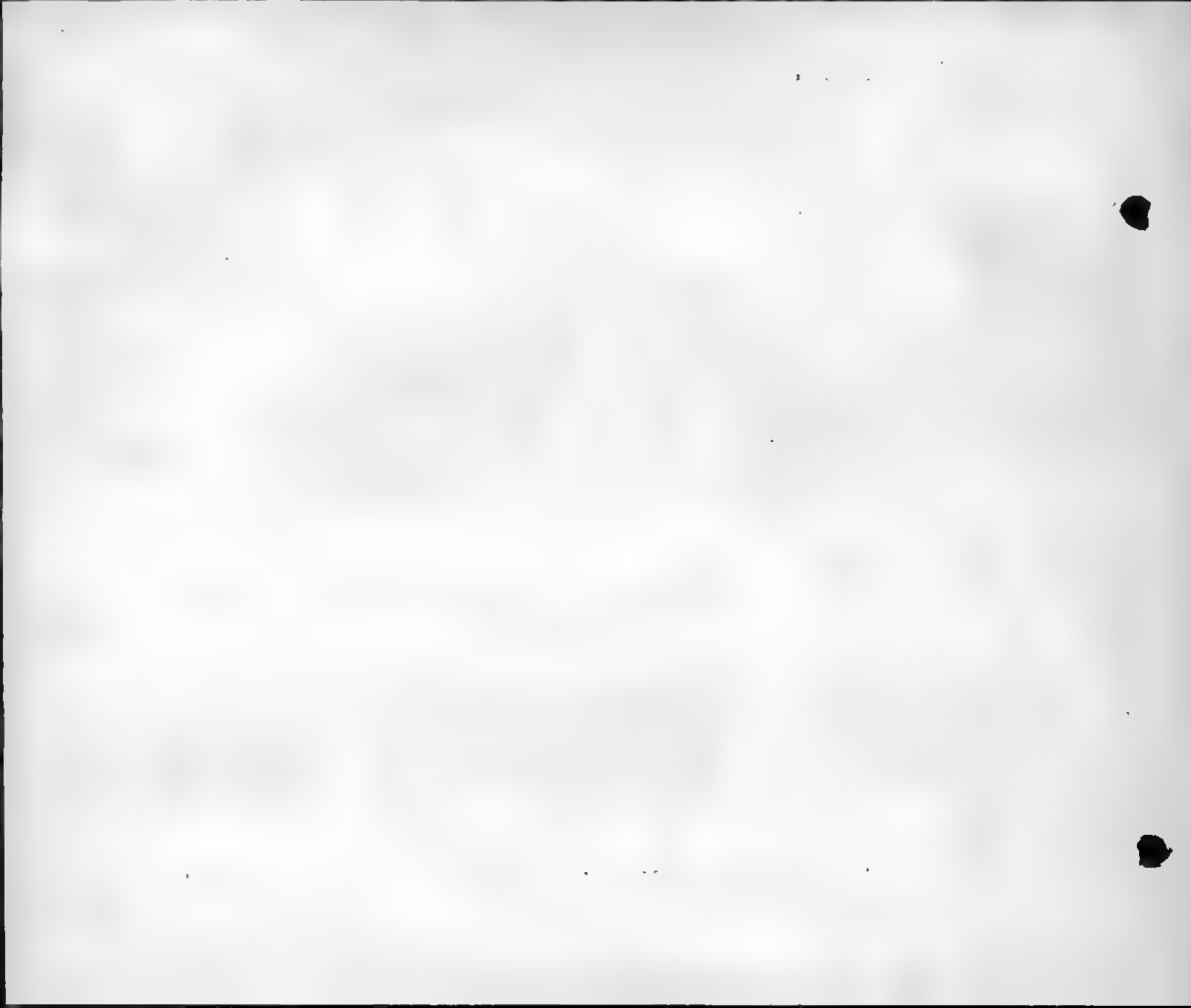
03991

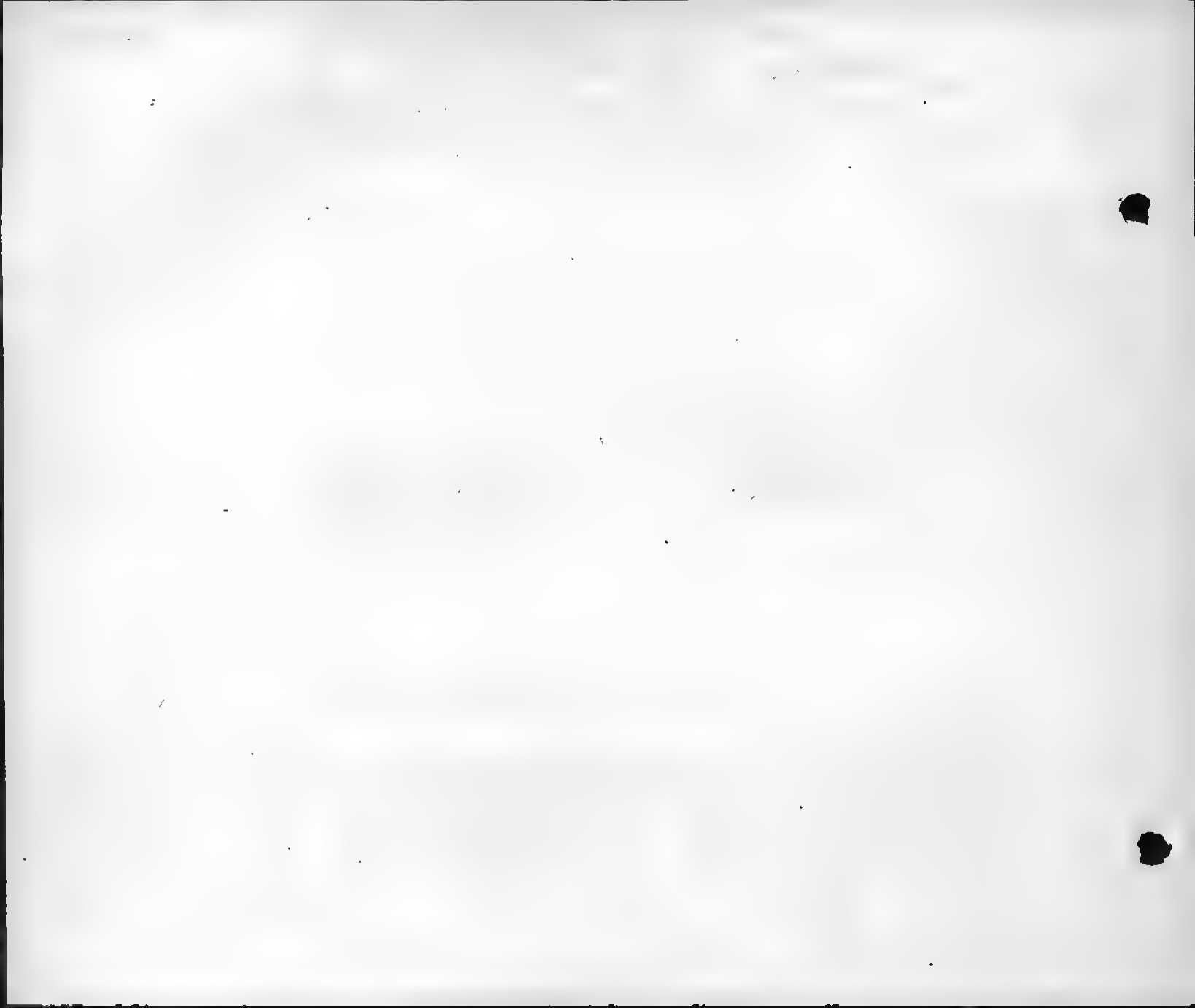
Reg. Dist. No.

10030

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 22 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2722 Maple St.				h. STREET ADDRESS 2722 Maple St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle A. Last Lannon SA				4. DATE OF DEATH Month Sept. Day 4, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1898	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR IBM.		10b. KIND OF BUSINESS OR INDUSTRY BANK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE LANNON				14. MOTHER'S MAIDEN NAME ROSE BRADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 16		17. INFORMANT MRS E. A. LANNON, Sr.		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. Bradley King, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				DATE SIGNED Sept. 4, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) _____ (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHAR F. EVANS				ADDRESS 8802 Harford Rd		24a. REC'D BY REGISTRAR DATE SEP 9 '60	
						24b. REGISTRAR'S SIGNATURE Charles S. King	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

VR AIS (4)
ISM 9/59

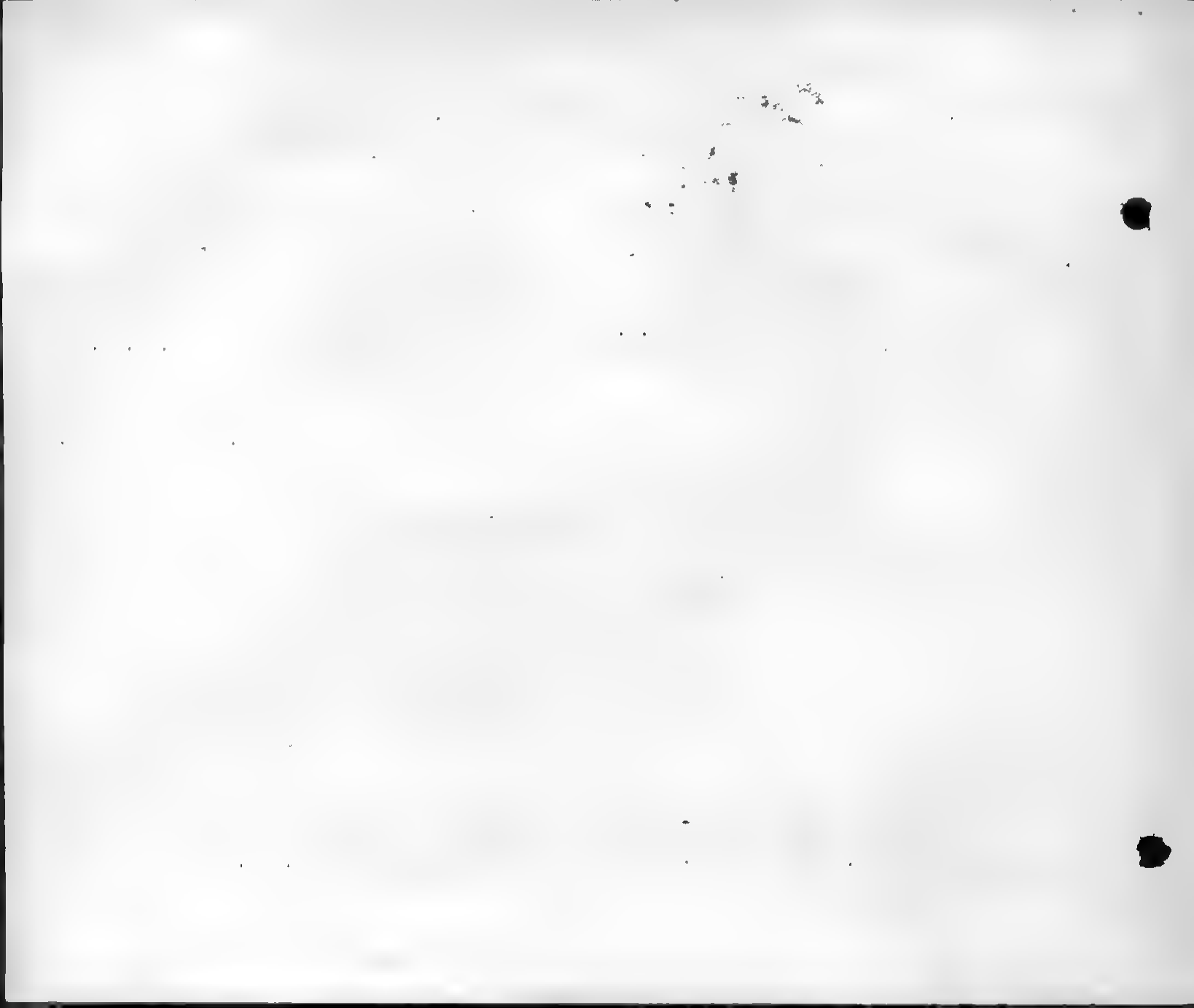
may be used by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10032
M
050

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09993

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 5 Hrs. 40 M.		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore (23)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1309 W. Mulberry Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last HARDY ---- IASSITER		4. DATE OF DEATH Month Day Year September 21 19 60	
5 SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 25, 1895
9 AGE (In years last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY /Ord Depot.	
11 BIRTHPLACE (State or foreign country) Wilson N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Lassiter		14. MOTHER'S MAIDEN NAME Isabelle Gear	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-05-9157	
17 INFORMANT Clin. Rec., VAH, Balto. 18, Md.		Address FT. HOWARD DIVISION	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE EDEMA OF LUNGS DUE TO HYPERTROPHY AND DILATATION OF THE HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ANEURYSM, ABDOMINAL AORTA (b) MARKED GENERALIZED ARTERIOSCLEROSIS (c)		INTERVAL BETWEEN ONSET AND DEATH 4 HOURS UNKNOWN UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2:40 PM, September 21 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Sept. 21 1960	
21 I certify that X (this hospital) attended the deceased from 8:20 to Sept. 21 1960 , that X (we) last saw the deceased alive on Sept. 21 1960 , and that death occurred at P M, from the causes and on the date stated above			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE 9/22/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS 1808 N. Monroe St. Balto. 17		25b. REGISTRAR'S SIGNATURE John S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and must be retained within 72 hours after death.

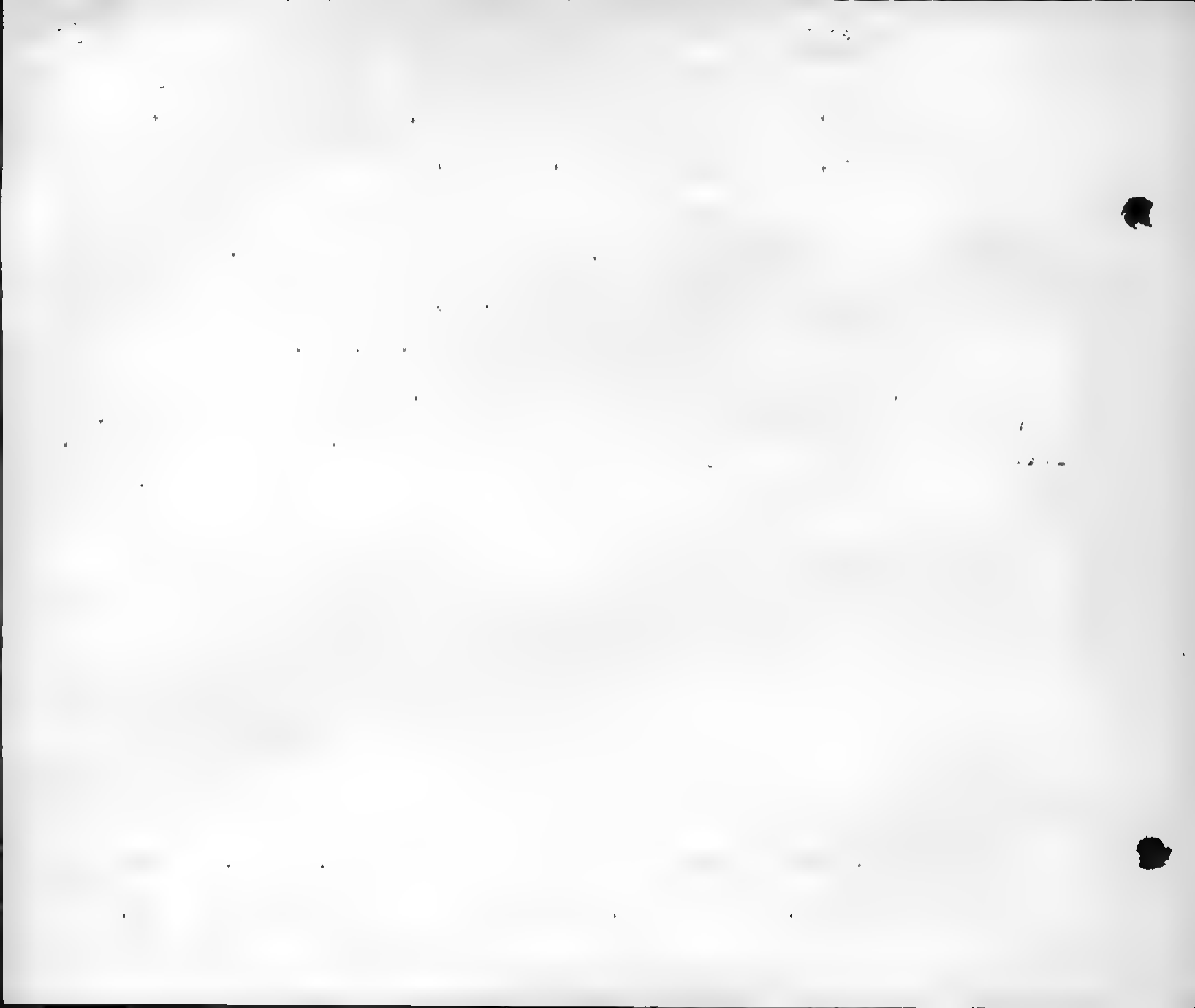
VR A15 (4)
15M 9/59

10033

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09994

1 PLACE OF DEATH a. COUNTY Balto. MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale Balto. 7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 7	
c. LENGTH OF STAY IN 1b 1 1/2 yrs.		d. STREET ADDRESS 3616 Kenmar Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle E. Last Liebno		4. DATE OF DEATH Month Sept. Day 20 Year 19 60	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1883
9 AGE (In years last birthday) 77 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b KIND OF BUSINESS OR INDUSTRY None
11 BIRTHPLACE (State or foreign country) Balto. Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George W. Sauter		14 MOTHER'S MAIDEN NAME Annie E. Schlining	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Lillian E. Sauter		Address Balto. 7 3616 Kenmar Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive C. V. Rnd Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 Years			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 13 1953 to Sept 22 19 60 that (I) (we) last saw the deceased alive on 9/14 19 60 and that death occurred at 4:50 P M, from the causes and on the date stated above.			
22a. SIGNATURE Edwin Pierpont		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont		22d. ADDRESS 8204 Liberty Rd. Balto. 7, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 23, 1960	
23c NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d LOCATION (City, town, or county) (State) Randallstown, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
ADDRESS 8728 Liberty Rd. Randallstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



10034

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>5</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Nursing Home</i> <i>98 Smithwood Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mrs. Laura</i> Middle <i>J.</i> Last <i>Lutz</i>		4. DATE OF DEATH Month <i>September</i> Day <i>19</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 24, 1872</i>
9. AGE (in years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>19</i> Hours <i>19</i> Min.	11. IF UNDER 24 HRS Months <i>8</i> Days <i>19</i> Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Bussey</i>		14. MOTHER'S MAIDEN NAME <i>Gleason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>Mrs. Agnes Hubbard 5007 Hillen Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>445x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-Vascular Disease with Acute & Chronic Failure</i> (c) <i>Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Scalp Laceration Rt. Occiput Recent.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 60</i> to <i>9/19/60</i> , that I last saw the deceased alive on <i>9/16/60</i> and that death occurred at <i>11:35 AM</i> , from the causes and on the date stated above.		DATE SIGNED <i>9/19/60</i>	
ACTUAL SIGNATURE <i>W.E. McGroth</i> M.D.		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 28md</i>	
PHYSICIAN'S NAME (Type) <i>W.E. McGroth</i>		22a. REC'D BY REGISTRAR DATE <i>SEP 22 '60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

1

4

(M)

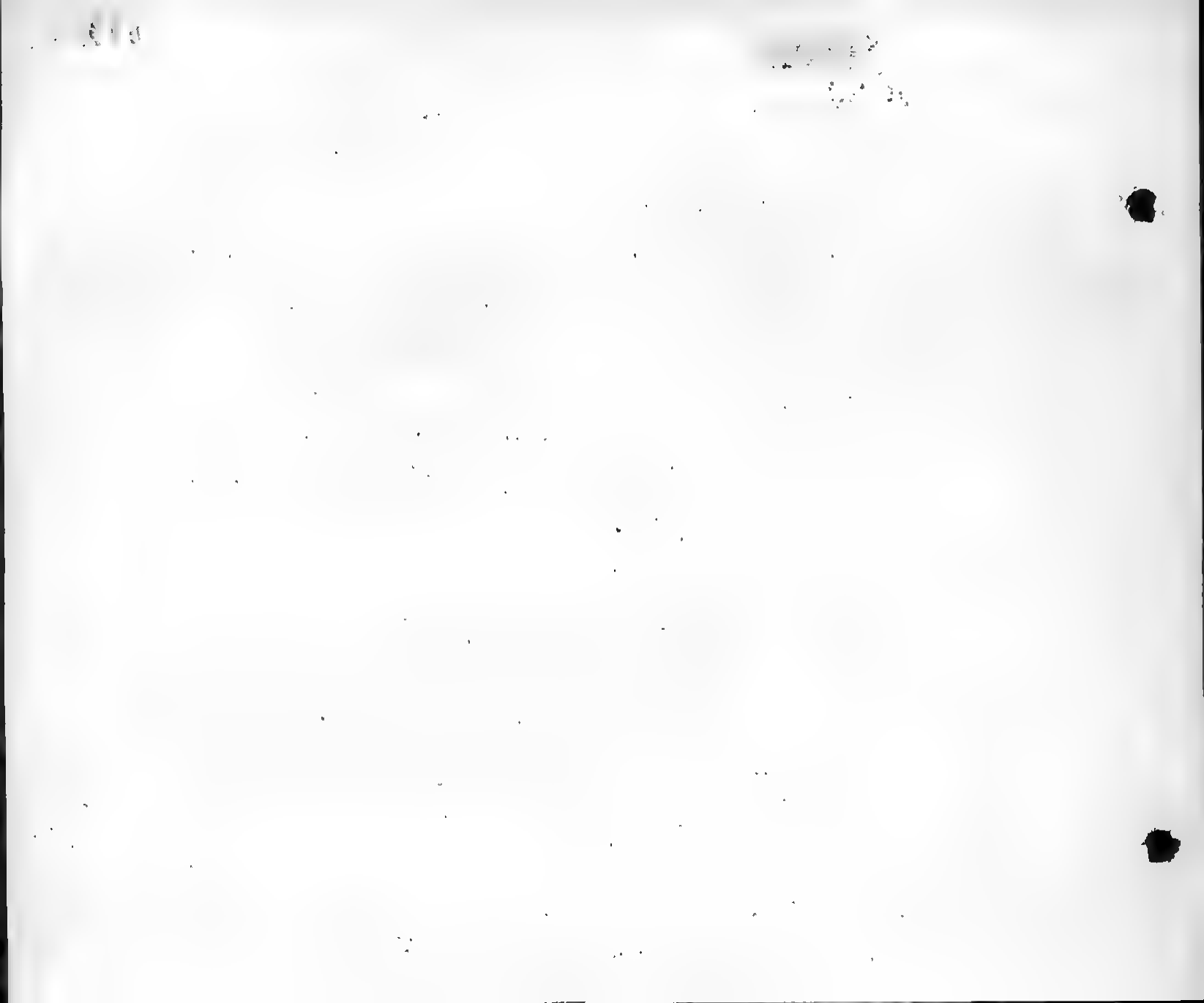
1/13

1

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10035
CERTIFICATE OF DEATH

09996

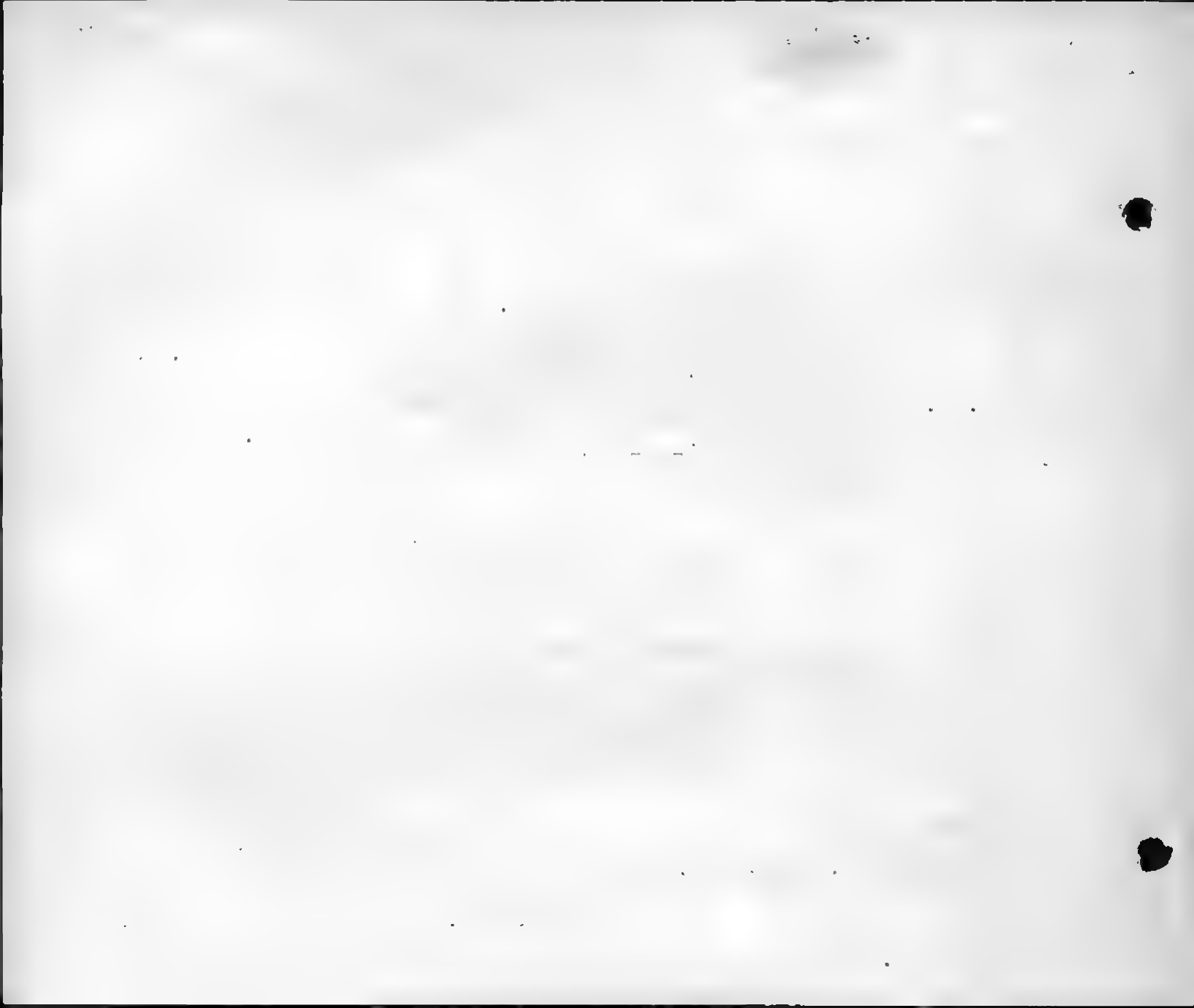
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE Maryland COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 1544-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Elmer Last Lynch		4. DATE OF DEATH Month September Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1895
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman		10b. KIND OF BUSINESS OR INDUSTRY hardware firm providing supplies for U. S. Forces	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Geo. W. Lynch		14. MOTHER'S MAIDEN NAME Annie E. McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. 577-22-8043	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Unknown Cause		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25, 1959 to Sept 5, 1960 that I last saw the deceased alive on Sept 5, 1960 , and that death occurred at 4:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED September 6, 1960 The Sheppard and Enoch Pratt Hospital Towson 4, Maryland			
ACTUAL SIGNATURE OF PHYSICIAN W. W. Elgin		M.D.	
PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>House In The Pines, Catonsville, Md. 202 Church Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elgar Milner Maglist</u>				4. DATE OF DEATH Month Day Year <u>September 24, 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Lutherville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Louisa Park Nursery</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William Maglist</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Tredway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>215-28-8555</u>			
17. INFORMANT <u>Baltimore 14, Md.</u>				18. ADDRESS <u>Mrs. Frances M. Andrews, 1755 Montworth</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca. of Pancreas with Metastasis</u>							
15X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 15th, 1960</u> to <u>Sept 24th, 1960</u> , that I last saw the deceased alive on <u>Sept 21st, 1960</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>				ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd. Pikesville 8, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>				DATE SIGNED <u>9/26/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10037

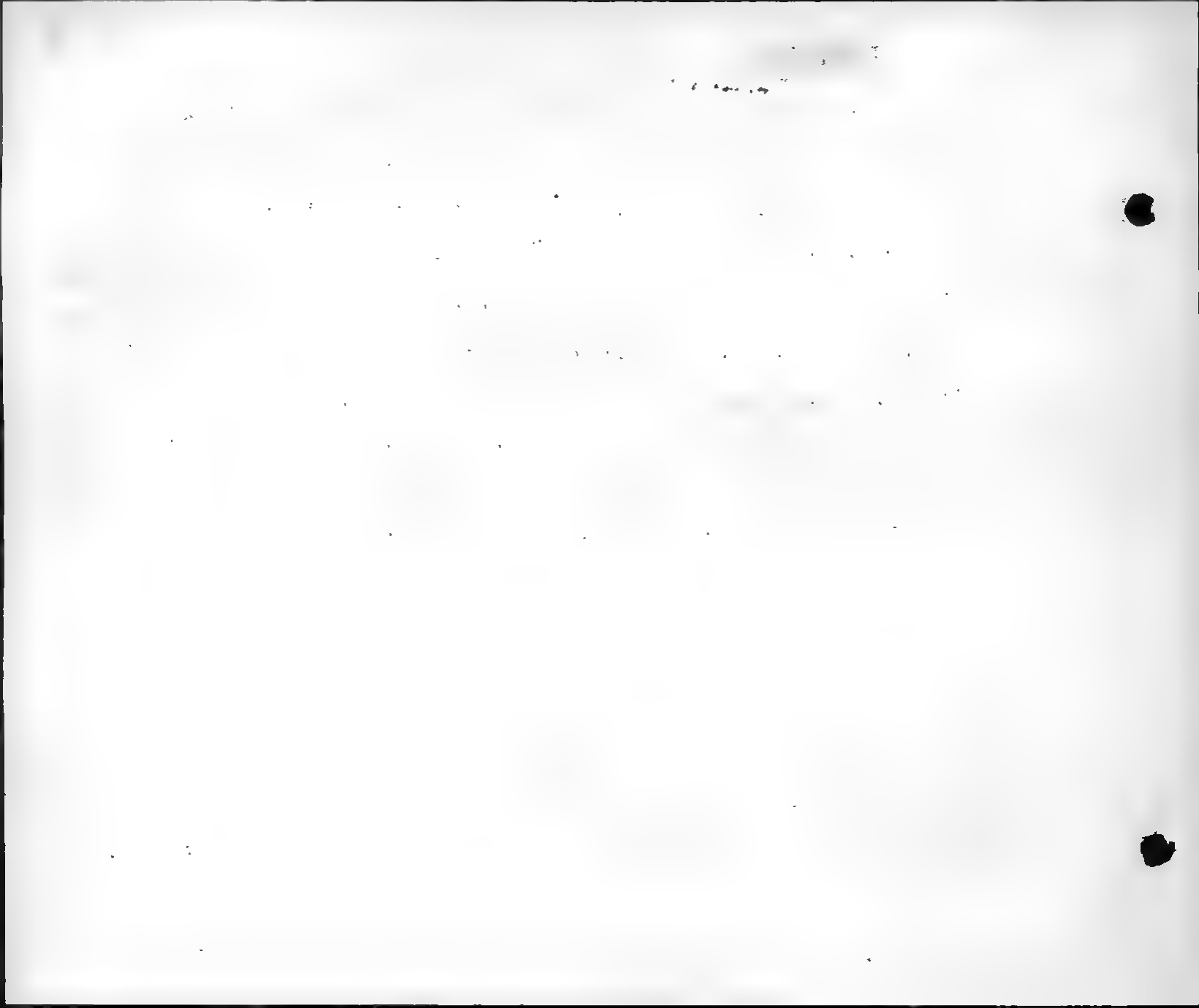
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosedale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosedale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8013 Duvall Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Robert Grafflin Mansfield</i>		4. DATE OF DEATH Month Day Year <i>September 17, 1960</i>	
5 SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 16, 1898</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>foreman Armco Co. Grinding Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John G. Mansfield</i>		14. MOTHER'S MAIDEN NAME <i>Annie Potts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Mrs. Margaret Agnes Mansfield</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 42 <i>Arteriosclerotic Heart Disease</i> DUE TO (b) <i>Syn.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 1957</i> , to <i>Sept 17, 1960</i> , that I last saw the deceased alive on <i>Sept 1, 1960</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5317 BELAIR Rd BALTIMORE 6, MD</i> DATE SIGNED <i>9/19/60</i>			
ACTUAL SIGNATURE <i>Emmett P Davis</i> M.D.		PHYSICIAN'S NAME (Type) <i>EMMETT P DAVIS</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-21-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Farkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 22 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

09999

9945

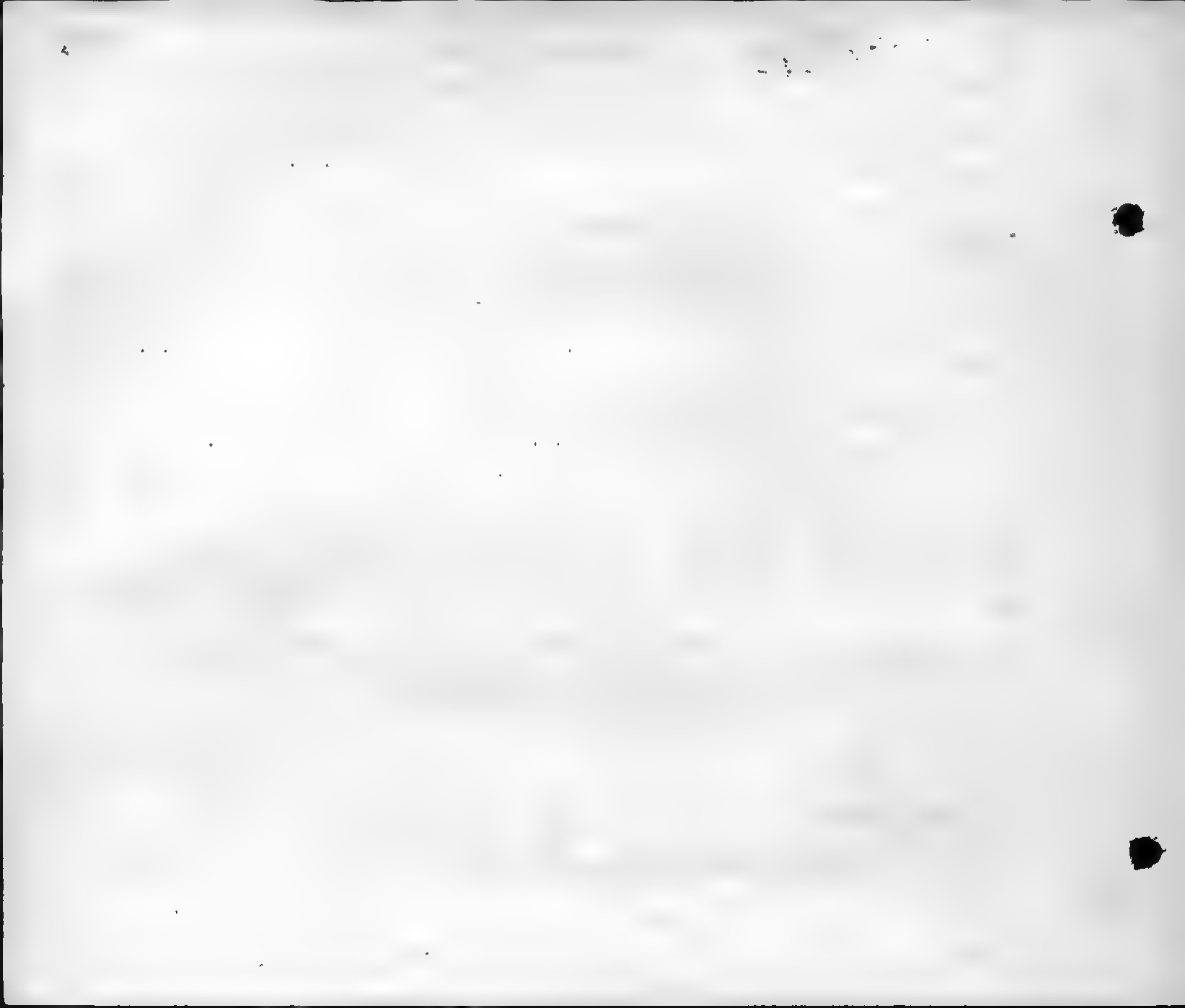
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore #27	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosemont		c. LENGTH OF STAY IN 1b 51 Rosemont	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2809 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAURITZ MATHISON (also Laurets & Lewis)		4. DATE OF DEATH Month Day Year Sept. 18, 1960 19	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1882
9. AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Lawrence Mathison		14. MOTHER'S MAIDEN NAME Caroline (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. 217 07 4019	
17. INFORMANT Thilda E. Mathison, 2809 Pennsylvania Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac - coronary aneurysm - pulmonary embolism DUE TO (b) ca of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-27-1959 to 9-18-1960 , that (I) (we) last saw the deceased alive on 9-18-1960 , and that death occurred at 8:30 AM , from the causes and on the date stated above			
22a. SIGNATURE Eugene Schnitzer		22b. DATE SIGNED SEP 21 '60	
22c. PHYSICIAN'S NAME (Type) Eugene Schnitzer, M.D.		22d. ADDRESS 3904 S. HANOVER ST. Balto. 25 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/22/60	23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge	23d. LOCATION (City, town, or county) (State) Howard Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25. REC'D BY REGISTRAR 4107 Wilkens Ave	
25b. REGISTRAR'S SIGNATURE Robert L. Turner			

MEDICAL CERTIFICATION



22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
	Sept-20-60	Greenmont	Baltimore	Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Stewart & Mowen Co.,		108-W North-Av. Balto 1, Md	DATE SEP 19 '60	Richard S. Mowen

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10001

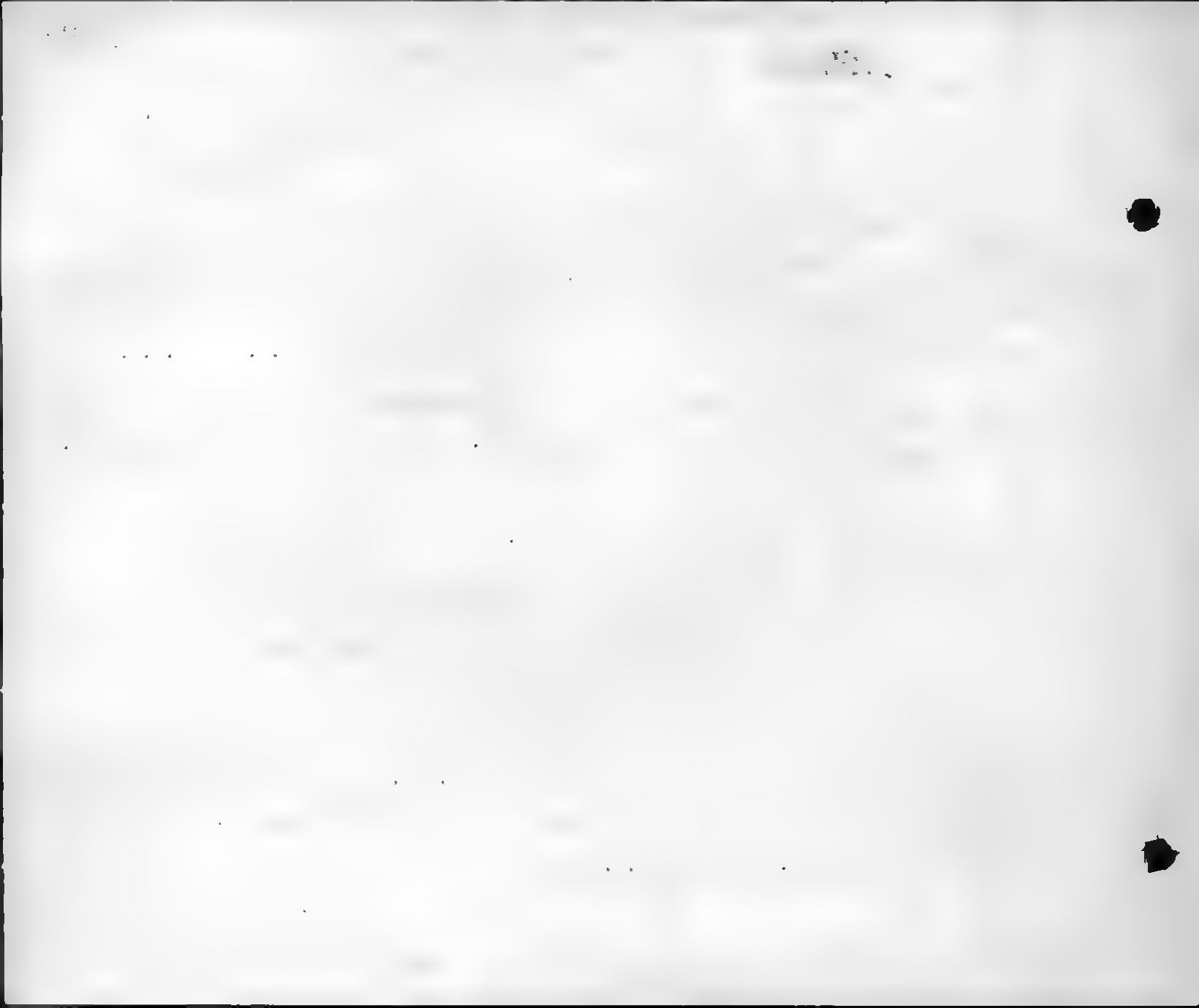
Reg. Dist. No.

10039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Josefita McCloskey		4. DATE OF DEATH Month Day Year Sept. 5 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Saratoga Springs, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael MC Closkey		14. MOTHER'S MAIDEN NAME Mary Ann Cody	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourrier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of large bowel- metastasis to bone & lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia due to above. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18 , 19 56 , to Sept. , 19 60 , that I last saw the deceased alive on August 31 , 19 60 , and that death occurred at 2.15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED 9/5/60	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-7-60.	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NK TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Zeiler ADDRESS 9015 CONKLIN ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR SEP 8 '60	
		24b. REGISTRAR'S SIGNATURE Charles J. Zeiler	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut an. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Pikesville</u>				c. LENGTH OF STAY IN 1b <u>10 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROBB CONVAL HOME Pikesville, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene</u> First <u>McDONALD</u> Middle <u>McDONALD</u> Last <u>McDONALD</u>				4. DATE OF DEATH <u>Sept 29</u> 19 <u>60</u> Month <u>Sept</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16, 1878</u>	
9. AGE (In years lost birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>		11. AGE (In years lost birthday) <u>82</u> yrs		12. IF UNDER 24 HRS Months <u>8</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORES</u>			
11. BIRTH PLACE (State or foreign country) <u>York Co., PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>AGUILLA McDONALD</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GEMMILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-01-9957</u>			
17. INFORMANT <u>Dore Anderson Jarrettville, Md.</u> Address <u>Jarrettville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>							
331X DUE TO (b) <u></u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>60</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 7</u> 19 <u>60</u> to <u>29 Sep 60</u> that I last saw the deceased alive on <u>Sept 7</u> 19 <u>60</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Paul H Royce</u> M.D.				ADDRESS (Street, city or town, state) <u>1403 Folcyl Lane Pikesville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royce</u>				DATE SIGNED <u>29 Sep 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CENTRE PRESBY. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>New York, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshman</u> ADDRESS <u>Stewartstown, Pa.</u>				24a. REC'D BY REGISTRAR <u>OCT 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



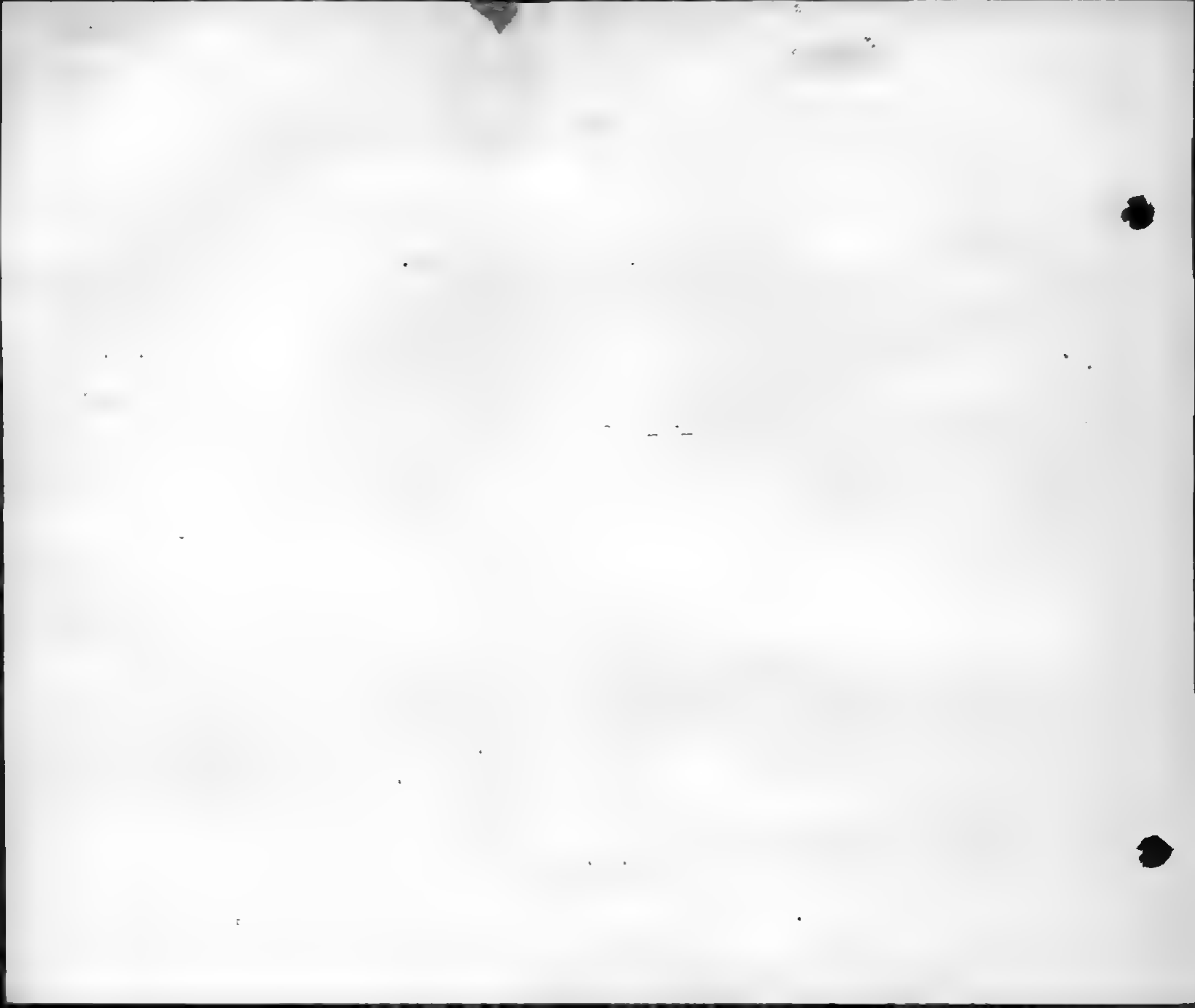
10041

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10003

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Neal Last McFaul Jr.				4. DATE OF DEATH Month September Day 21 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1903		9. AGE (In years lost birthday) 56 yrs	IF UNDER 1 YEAR Months 56 Days 0	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10b. KIND OF BUSINESS OR INDUSTRY medicine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William McNeal McFaul				14. MOTHER'S MAIDEN NAME unknown Mary Elizabeth Caltrider			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO 218-38-2923		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral acute pyelonephritis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960 to Sept. 21, 1960 , that (I) (we) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at 2:40 M, from the causes and on the date stated above.							
22a. SIGNATURE Stella Wechsler				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-21-60	
22c. PHYSICIAN'S NAME (Type) Stella Wechsler, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Walter H. Burge				ADDRESS 3631 Falls Road		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

4000

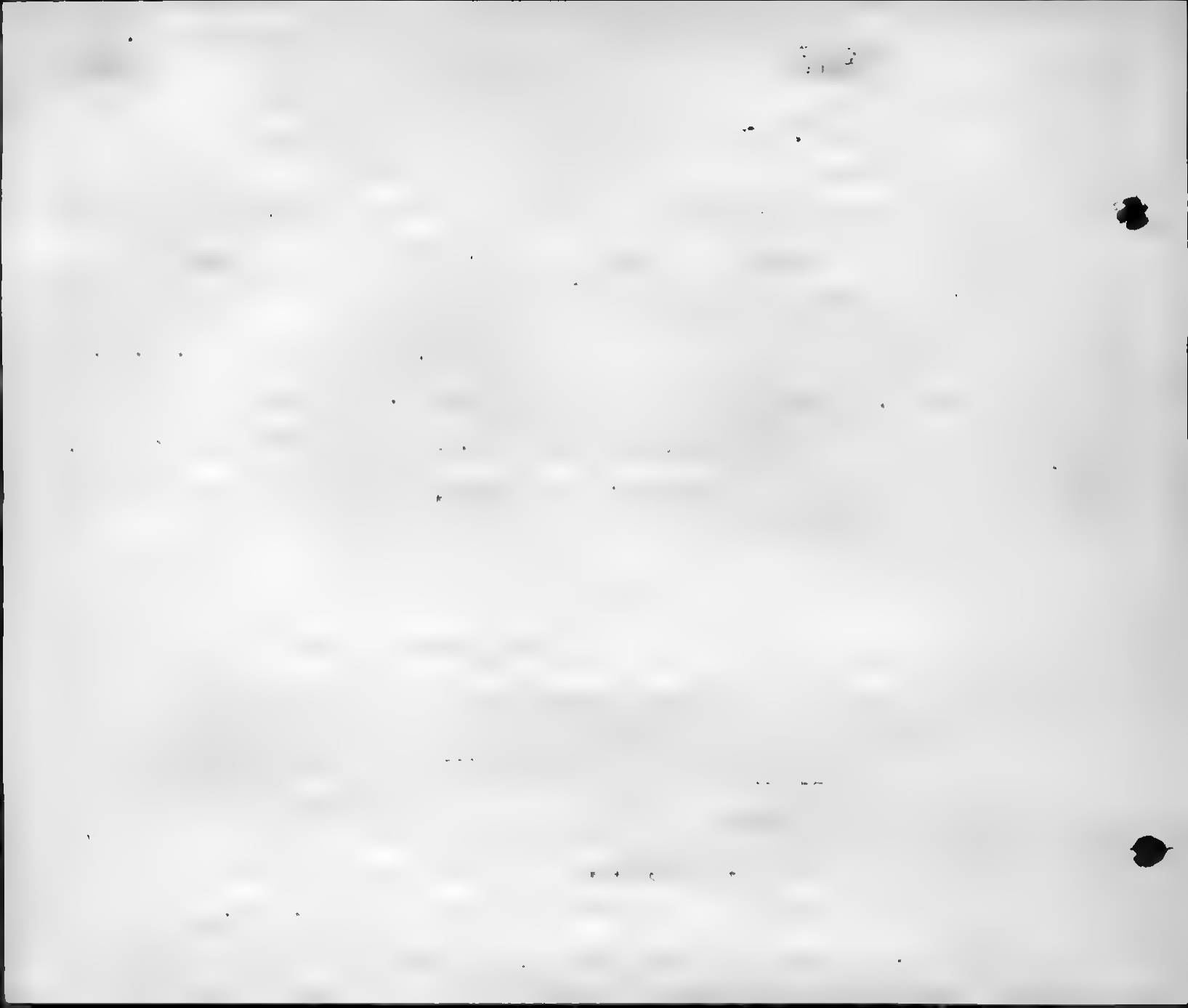
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10004

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1244 Ten Oak Road		d. STREET ADDRESS 1244 Ten Oak Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARK		4. DATE OF DEATH Month Day Year September 30 19 60		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.		11. BIRTH (Place, State or foreign country) Baltimore Md.	
13. FATHER'S NAME Billy D. McKissick		14. MOTHER'S MAIDEN NAME Joyce O. Schoeppler		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Billy D. McKissick 1244 Ten Oaks Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Interstitial Pneumonitis. (c)		INTERVAL BETWEEN ONSET AND DEATH _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASS. STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Petty, M.D.		DATE SIGNED 9/30/60	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR OCT 4 '60	
				24b. REGISTRAR'S SIGNATURE _____	



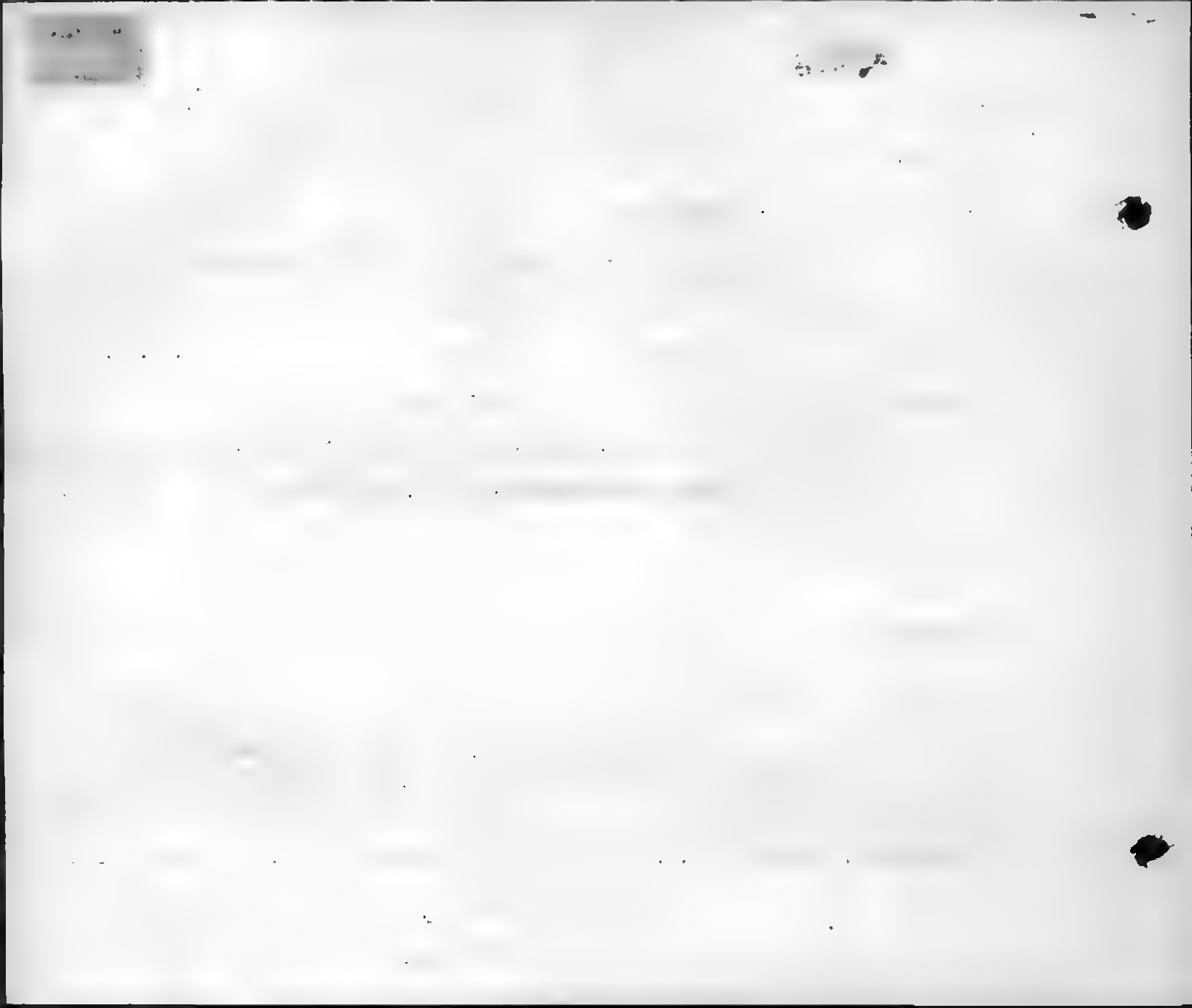
may be recorded by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-42

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10005

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Queen Annes			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 52 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle B. Last MILLER				4. DATE OF DEATH Month September Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1910	
9. AGE (In years last birthday) 49 yrs		F UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.		IF UNDER 24 HRS. Months 49 Days 49 Hours 49 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Benjamin L. Miller				14. MOTHER'S MAIDEN NAME Annie Anthony			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO 219-07-7101		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) WIDESPREAD ADENOCARCINOMA, PRIMARY UNKNOWN DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) 199.2 (c) 2 1/2 YRS.				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from July 18, 1960 , to September 8, 1960 , that (X) (we) last saw the deceased alive on Sept. 8, 1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 9/8/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 13, 1960		23c. NAME OF CEMETERY OR CREMATORY Centerville Cemetery		23d. LOCATION (City, town, or county) (State) Centerville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Barton Brothers Funeral Directors, Centerville, Md.				25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE William S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 372 10-3-60 et

CERTIFICATE OF DEATH

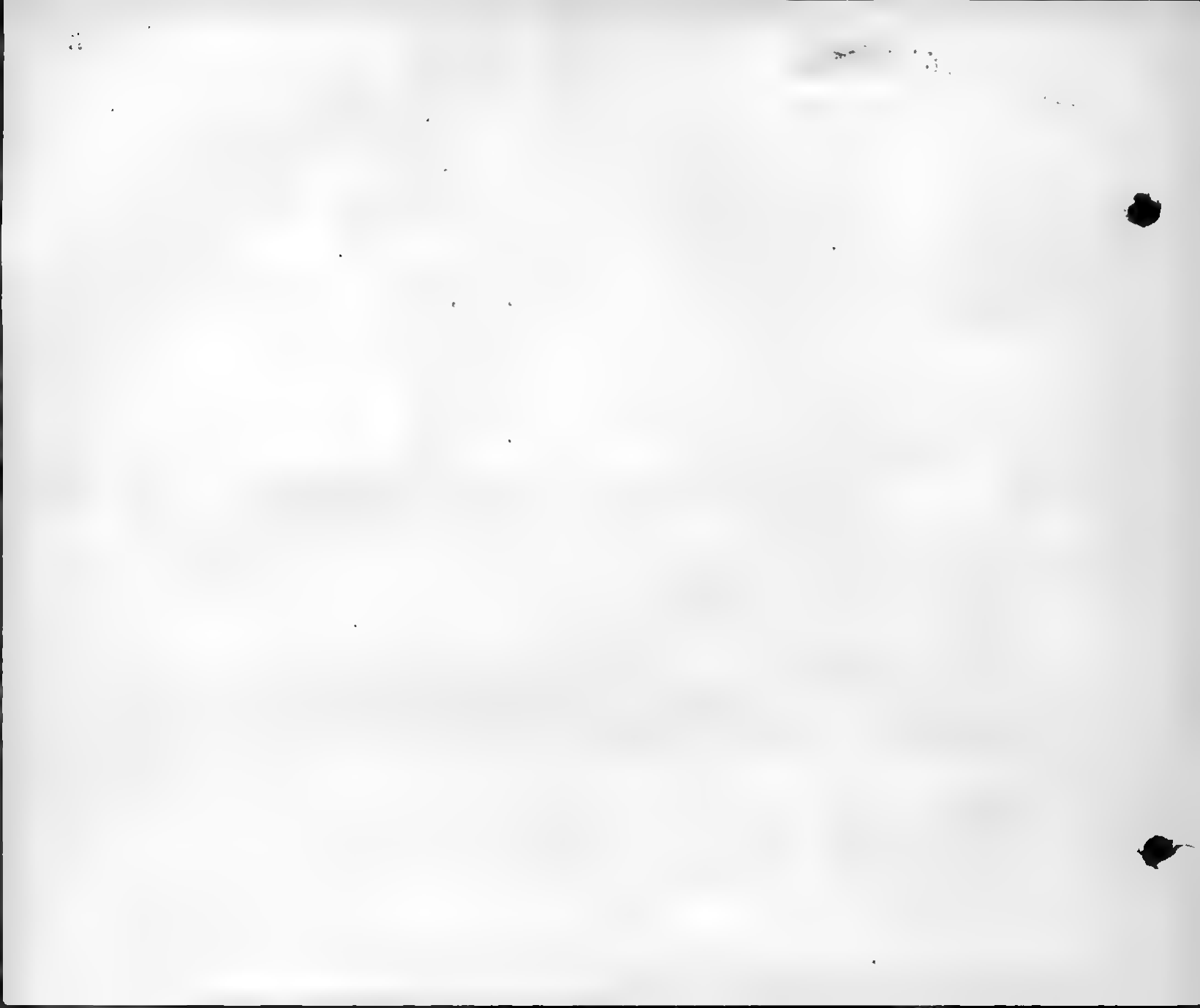
Reg. Dist. No.

10043

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6700 Selkirk Road</u>		d. STREET ADDRESS <u>6700 Selkirk Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Barbara Minnick</u>		4. DATE OF DEATH <u>September 27 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1883</u>
9. AGE (In years last birthday) <u>76 1/4</u> yrs		IF UNDER 1 YEAR: Months <u>11</u> Days <u>14</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Jacob Jondo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Melicher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Alfred Chris</u>		Address <u>6700 Selkirk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>Severe Anemia, probably from hemorrhage</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u>			
DUE TO (b) <u>Carcinoma bladder</u>			
DUE TO (c) <u>12 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 19, 1960</u> to <u>Sept 27, 1960</u> , that I last saw the deceased alive on <u>9-25-60</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Joseph F. Philbin, M.D.</u>		ADDRESS (Street, city or town, state) <u>8405 Woodhaven Rd Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph F. Philbin</u>		DATE SIGNED <u>9/27/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morlena Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

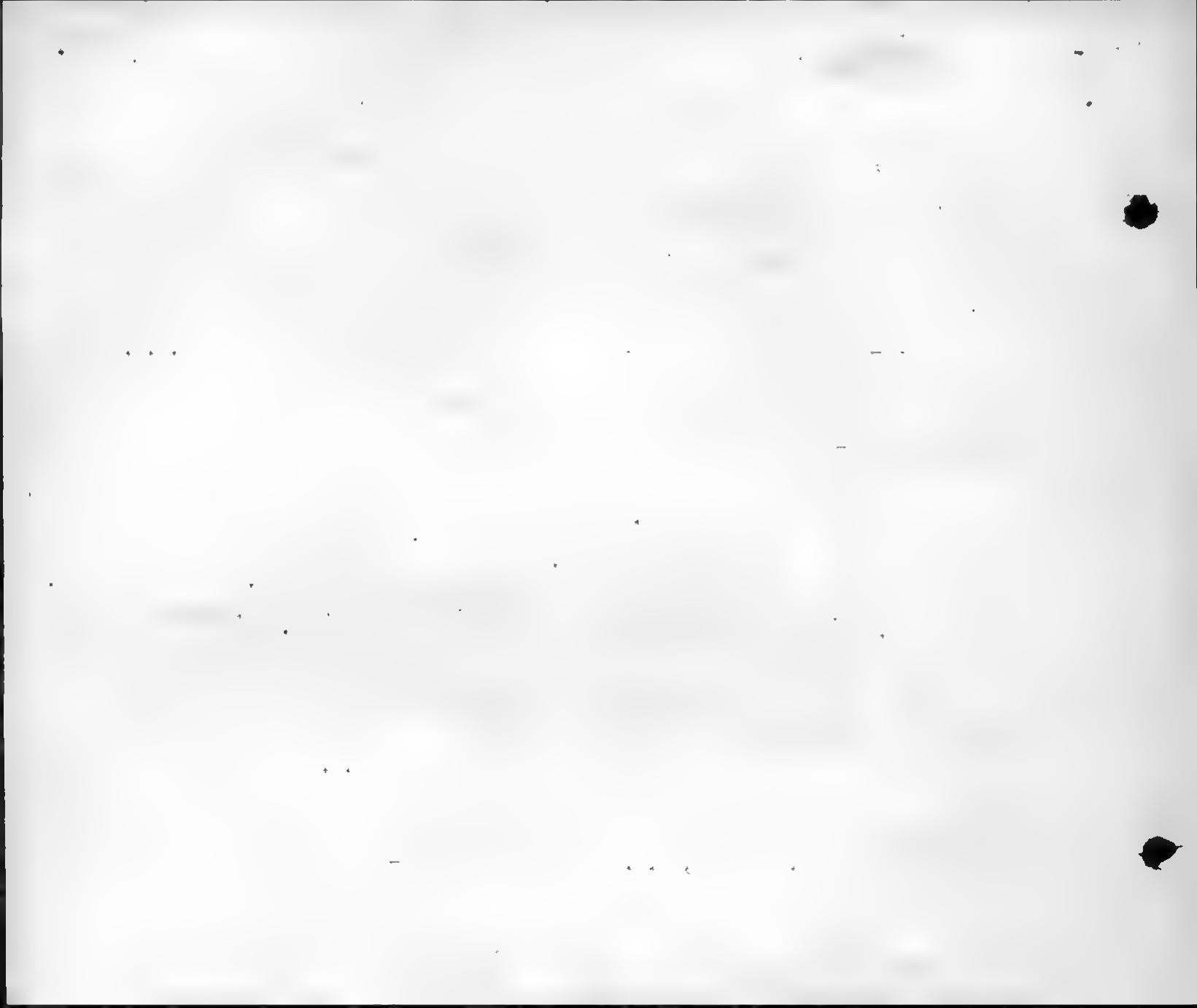


may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10007

10044

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
a. COUNTY Baltimore MARYLAND				a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 36-years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 1112			
3. NAME OF DECEASED (Type or print) First Phillip Middle Beckwith Last Mowbray				4. DATE OF DEATH Month 9 Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/16	
9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				Maryland			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Mowbray				14. MOTHER'S MAIDEN NAME Susie Mowbray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) no				16. SOCIAL SECURITY NO. —			
17. INFORMANT Rosewood Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Embolism, pulmonary, due to circulatory disturbance							
DUE TO suspected.							
Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost							
(b) Thrombosis of vein of leg due to unspecified cause, suspected.							
(c) Varicose veins of legs due to unknown cause.							
INTERVAL BETWEEN ONSET AND DEATH 20-min.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Edema of legs, dermatitis hypostaticum, recent prolonged bed rest. Elderly Mongoloid. Recent studies of heart, lungs, kidneys negative.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/58 to 9/2/60 , that (I) (we) lost the deceased alive on 9/2/60 , 19___, and that death occurred at 10:55 a.m. from the causes and on the date stated above							
22a. SIGNATURE Edward J. Mathews M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE SIGNED 9/2/60							
22c. PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D. 22d. ADDRESS Rosewood - Owings Mills, Maryland							
23a. BURIAL CREMATION REMOVAL (Specify) Removal							
23b. DATE THEREOF Sept 11, 1960							
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park (Cambridge) Md.							
23d. LOCATION (City, town, or county, (State) Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE La Compagnie Funeral Home Cambridge Md. ADDRESS Cambridge Md.							
25a. REC'D BY REGISTRAR SEP 7 '60							
25b. REGISTRAR'S SIGNATURE Arthur S. Knapp							



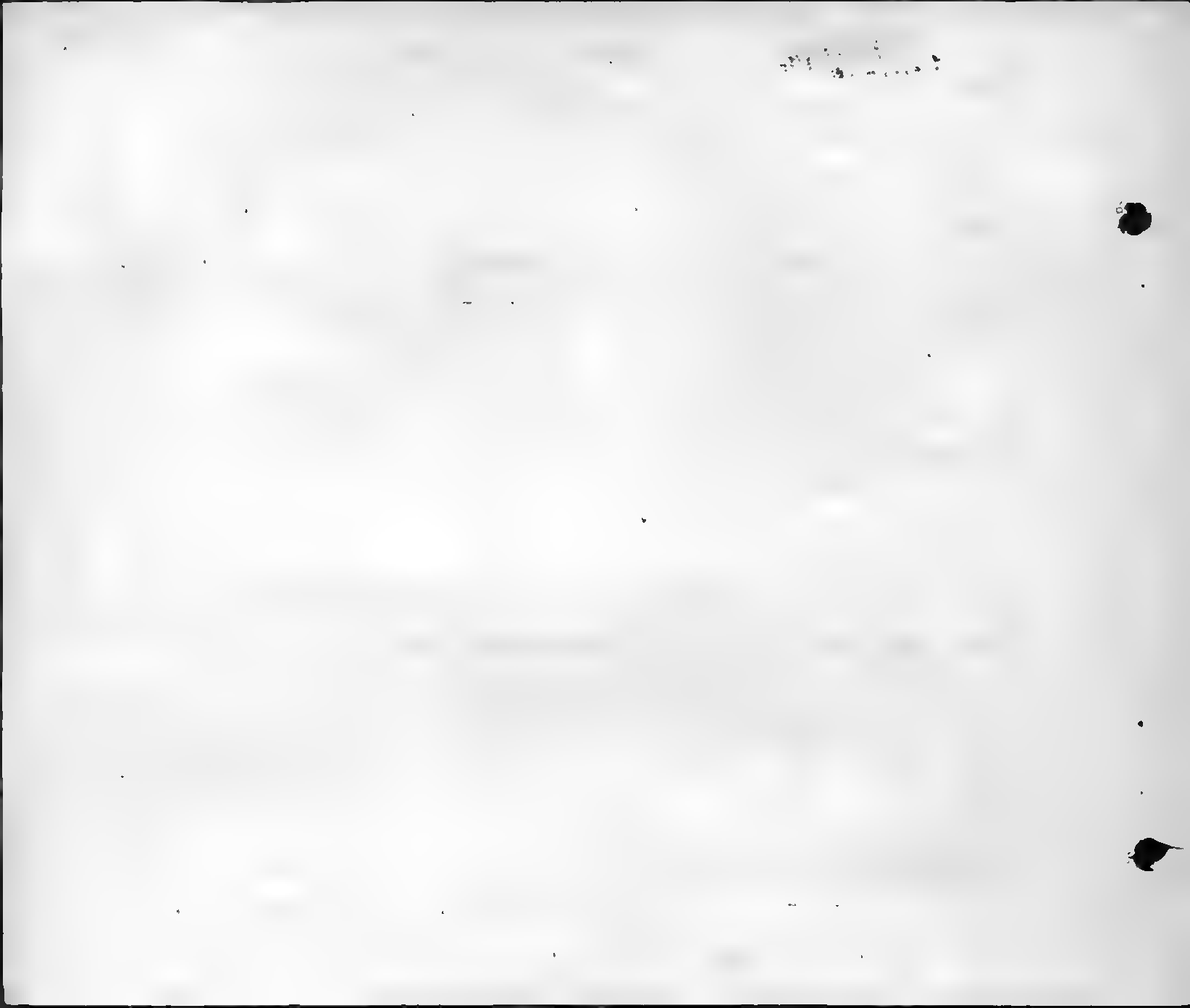
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

10045 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10008 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1657 Yakona Rd.</i>		d. STREET ADDRESS <i>1657 Yakona Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>Muffoletto</i> Last <i>Muffoletto</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-1876</i>
9. AGE (In years last birthday) <i>84</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Stone Mason</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Muffoletto</i>		14. MOTHER'S MAIDEN NAME <i>Rose (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs Rose Furnari</i>		Address <i>same</i>	
18. CAUSE OF DEATH: [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X Hypertensive cardio-vascular dis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>4 years</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1956</i> to <i>Sept 13</i> , 19 <i>60</i> that I last saw the deceased alive on <i>Sept 12</i> , 19 <i>60</i> , and that death occurred at <i>3 A.</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>R Donald Jandorf</i> M.D.			
PHYSICIAN'S NAME (Type) <i>R Donald Jandorf</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>9-16-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 16 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			



10046

CERTIFICATE OF DEATH

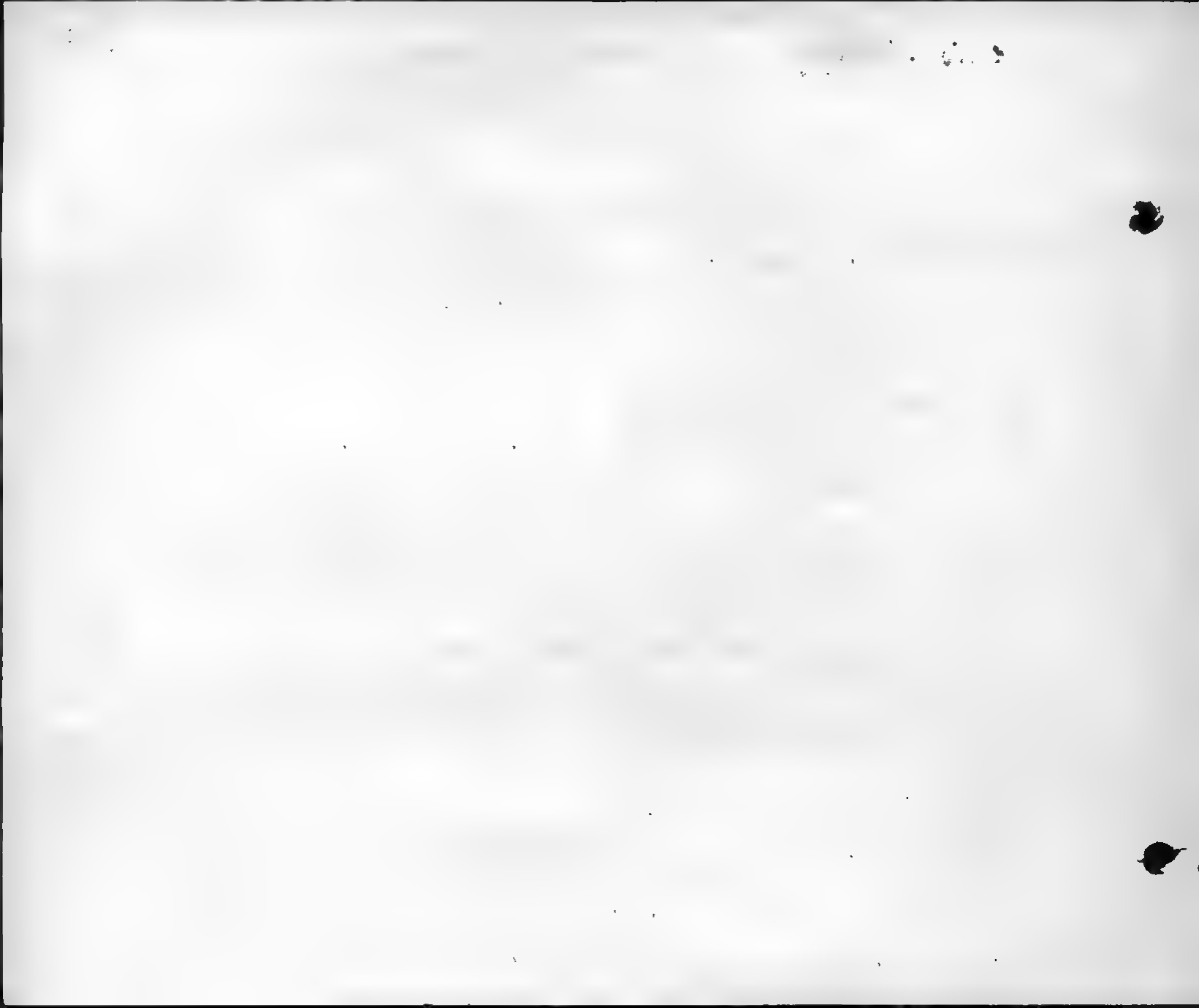
10009

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>525 Alleghany Avenue</u>		d STREET ADDRESS <u>525 Alleghany Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Rose H. Murray</u>		4 DATE OF DEATH <u>September 21, 19 60</u>	
5. SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Mar. 17, 1883</u>
9 AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Harford Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13 FATHER'S NAME <u>Martin Flavin</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Welsh</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16 SOCIAL SECURITY NO <u>217-36-4531</u>	
17 INFORMANT <u>Mrs. Margaret M. Rabel</u>		Address <u>525 Alleghany Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary atherosclerosis</u> (b) <u>Coronary atherosclerosis</u> DUE TO <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/22</u> , 19 <u>60</u> to <u>9/22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>9/22</u> , 19 <u>60</u> , and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>9/22/60</u>			
ACTUAL SIGNATURE <u>George T. Gilmore</u> M.D.		PHYSICIAN'S NAME (Type) <u>GEORGE T. GILMORE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d LOCATION (City, town, or county) (State) <u>Texas, Maryland</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a REC'D BY REGISTRAR DATE <u>SEP 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

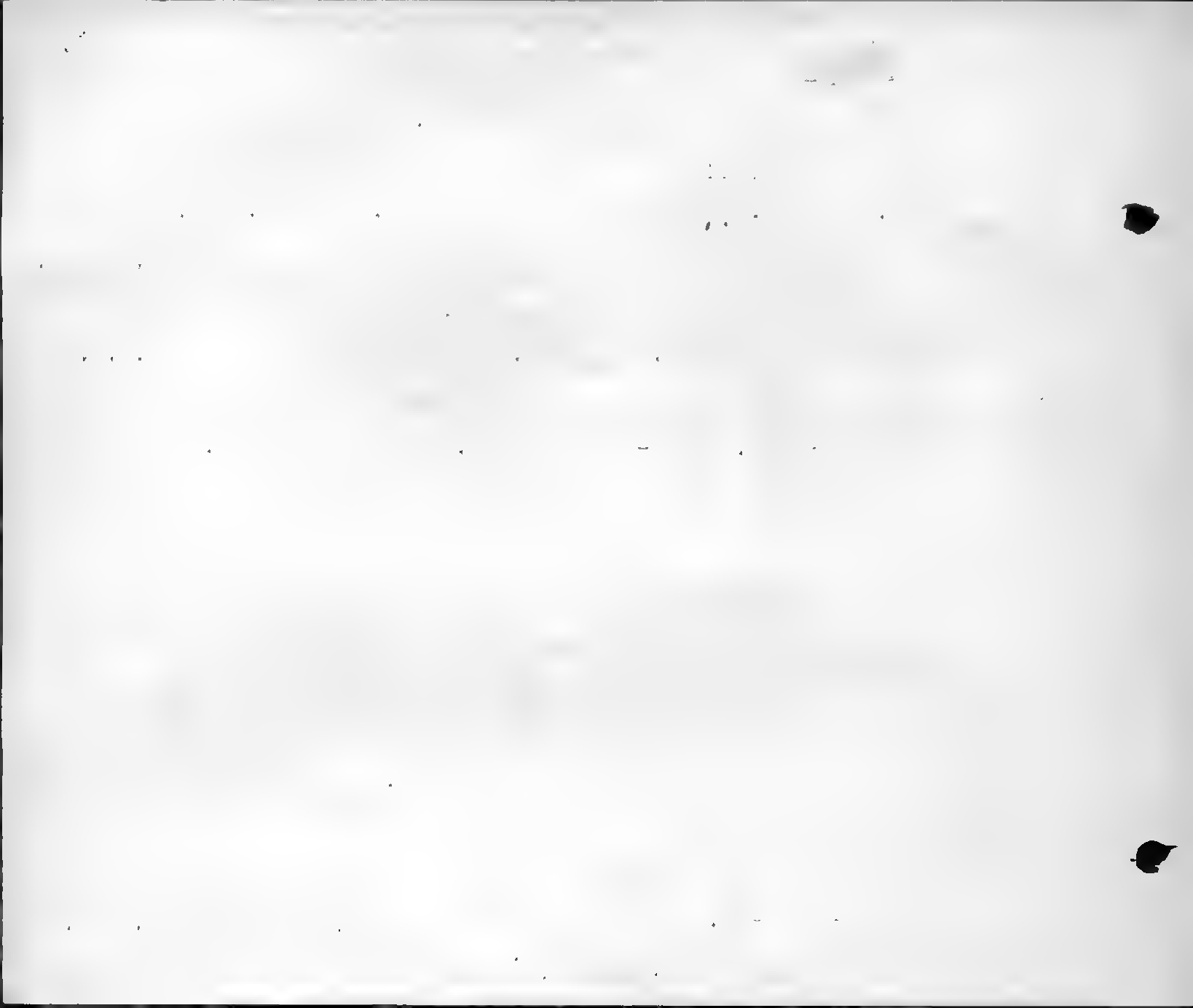
10048

CERTIFICATE OF DEATH

Reg. Dist. No. 10011

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbor View				c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbor View			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 S. 48th St. # 24				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TERJE Middle H. Last OLSEN				4. DATE OF DEATH Month September Day 9 Year 19 60.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1889	
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months 7 Days 19 Hours 60.		IF UNDER 24 HRS Months 7 Days 19 Hours 60.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Trans. Co.		11. BIRTHPLACE (State or foreign country) Tromso, Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Olsen				14. MOTHER'S MAIDEN NAME Betsy ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1912-1913.213-10-0938			
17. INFORMANT Eva K. Olsen				Address Same.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42.0.1 Coronary Occlusion DUE TO (b) Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 6 days 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1952 19 to Sept 9 1960, that I last saw the deceased alive on Sept 9 1960, and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Morris A. Jacobs				ADDRESS (Street, city or town, state) 1010 North Point Rd Balto 24			
PHYSICIAN'S NAME (Type) MORRIS A. JACOBS				DATE SIGNED 9/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. S. S. S. S.				ADDRESS 6224 Eastern Ave. Balto., 24, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
				24b. REGISTRAR'S SIGNATURE Carlton S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

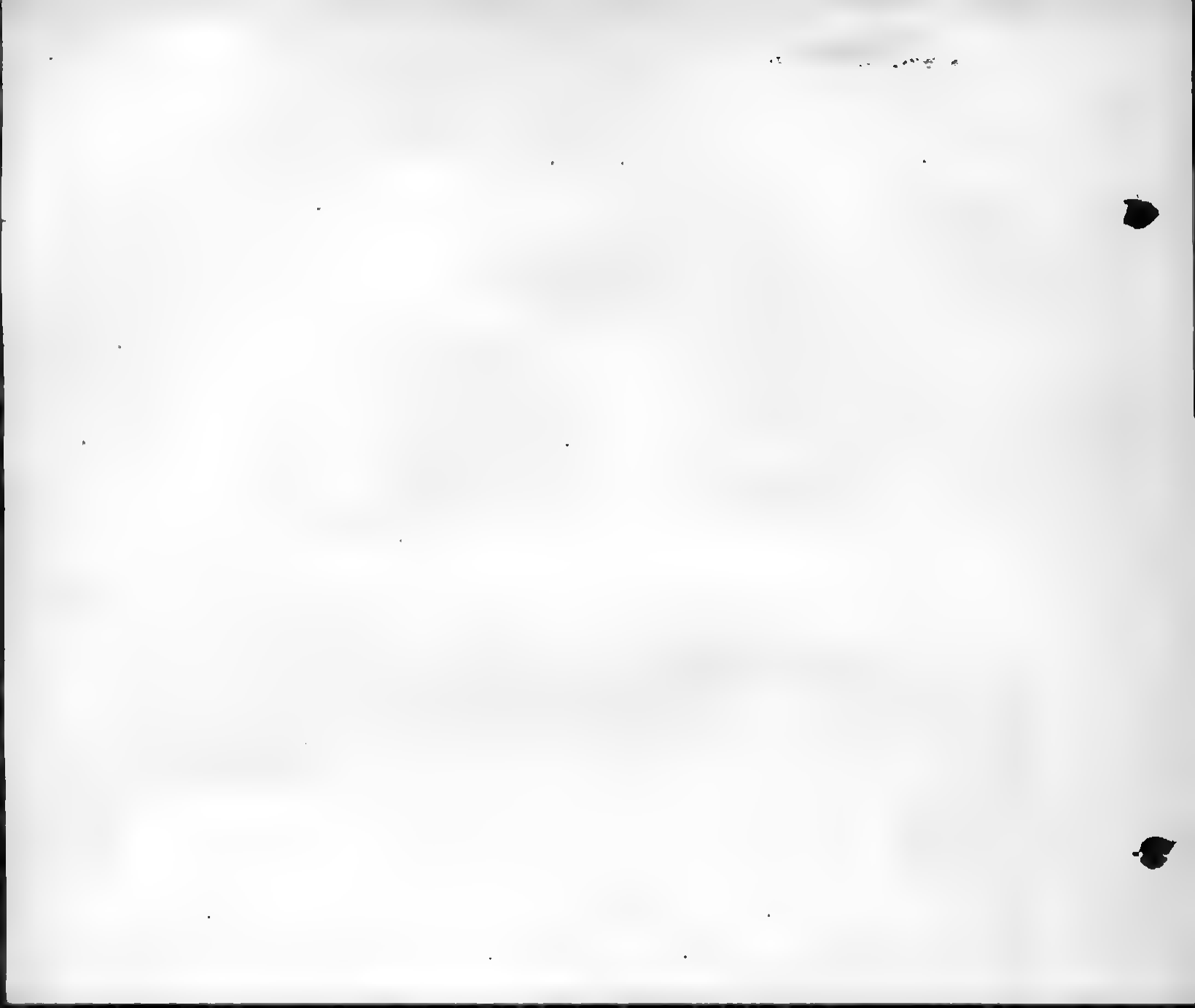
VR A11 (4)
ISM 9/59

10049

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10012

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Wings Mills Md.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Varian Last O'Neill		4. DATE OF DEATH Month 9 Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Maurice Thomas O'Neill		14. MOTHER'S MAIDEN NAME Judith Daly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Rosewood Records	
17. INFORMANT O'Wings Mills Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital internal 52. DUE TO hydrocephalus, marked Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 4-9 1958 to 9-17 1960 , that (I) (we) last saw the deceased alive on 9-17 1960 , and that death occurred at 11A , from the causes and on the date stated above.			
22a. SIGNATURE Dr. W. Rieckert		22b. DATE SIGNED 9-18-60	
22c. PHYSICIAN'S NAME (Type) Peter W. Rieckert		22d. ADDRESS 4207 Mainfield Ave. Balt 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		25a. REC'D BY REGISTRAR SEP 20 '60	
ADDRESS Baltimore Md.		25b. REGISTRAR'S SIGNATURE Charles P. Thomas	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10013

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN TB in transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
3. NAME OF DECEASED (Type or print) Noah First Peterson Last		4. DATE OF DEATH Month Sept. Day 17 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1941
9. AGE (in years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 19 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asplundh Tree Trimer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Floyd L. Peterson		14. MOTHER'S MAIDEN NAME Mamie Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-4674	
17. INFORMANT Mrs. Mamie Peterson		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 023X Severed rt. jugular vein, larynx, trachea IMMEDIATE CAUSE (a) Severed rt. jugular vein, larynx, trachea DUE TO (b) Severed rt. jugular vein, larynx, trachea DUE TO (c) Severed rt. jugular vein, larynx, trachea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) car moving S. bound, jumped curb & struck side of building.	
20c. TIME OF INJURY Month, Day, Year 9-17-60 Hour 1:05 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Main St.		20f. (City or town) (County) (State) Reisterstown, Balto., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 9-17-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or county) (State) Finksburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR SEP 20 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

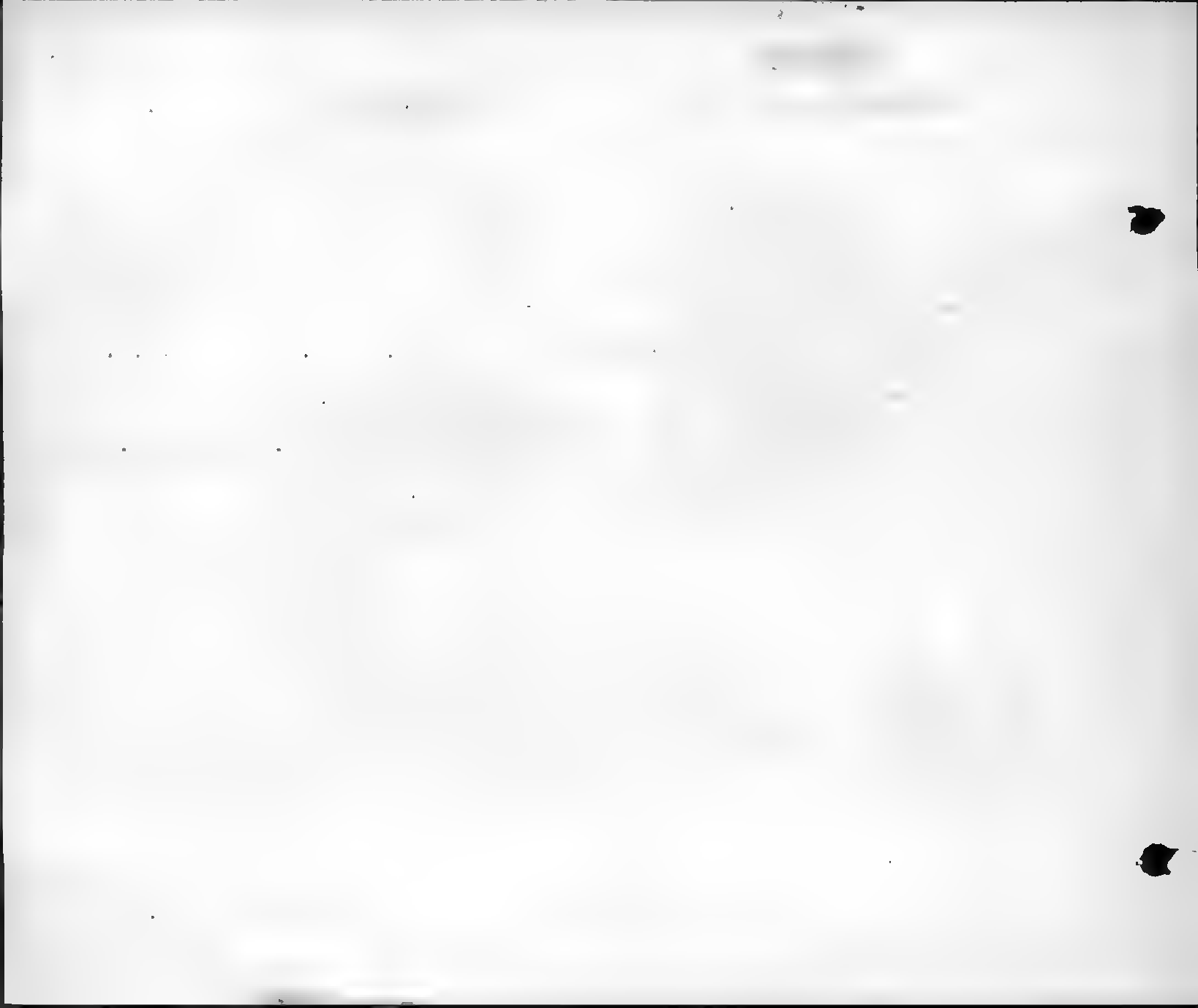
CERTIFICATE OF DEATH

Reg. Dist. No. 10014

1. PLACE OF DEATH a. COUNTY <u>Cockeysville</u> <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Cockeysville</u> <u>Balto. Md.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Warren Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Gray</u> Last <u>Peterson</u>				4. DATE OF DEATH Month <u>9--</u> Day <u>29</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>selfemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Emma Peterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Grayson Peterson, Sr. Warren Rd.</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u> DUE TO (c) <u>6 1/2</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>Sept 29, 1960</u> , that I last saw the deceased alive on <u>Sept 27, 1960</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.				ADDRESS (Street, city or town, state) <u>2000 York Rd., Timonium, Md. 5-33-00</u>			
PHYSICIAN'S NAME (Type) <u>William A. Pillsbury, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral service</u>				ADDRESS <u>622 York Rd-4-</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

M

I

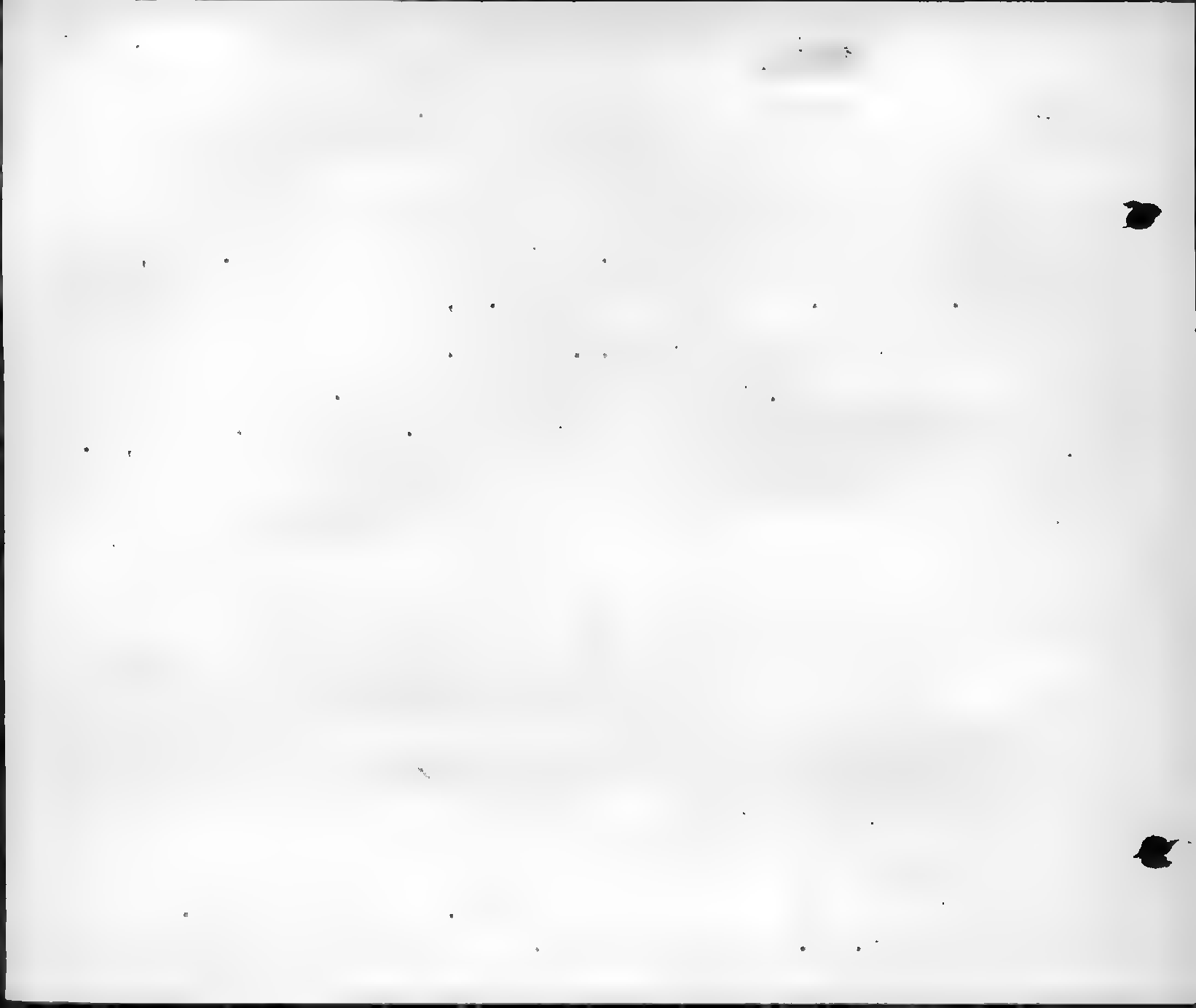


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <p>10051</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">10015</p> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 1							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 Beaumont Ave				d. STREET ADDRESS 221 Beaumont Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle M. Last Pitcher				4. DATE OF DEATH Month Sept. Day 22 Year 19 60							
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 27, 1877		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Repairman B & O R.R.				10b. KIND OF BUSINESS OR INDUSTRY Md.				11. BIRTHPLACE (State or foreign country) USA			
13. FATHER'S NAME James M. Pitcher				14. MOTHER'S MAIDEN NAME Margaret A. Key							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO <input type="checkbox"/>				17. INFORMANT Address Mrs Ralph M. Crawford Sr. 221 Beaumont Ave, Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) Chronic glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pikesville Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 22 1960 to Sept 22 1960 , that (I) (we) last saw the deceased alive on Sept 22 1960 , and that death occurred at 12:00 PM from the causes and on the date stated above											
22a. SIGNATURE J. Nelson McKay				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 9/23/60			
22c. PHYSICIAN'S NAME (Type) J. NELSON MCKAY, M. D.				22d. ADDRESS 6014 Edmondson Ave.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 9/24/60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemty.		23d. LOCATION (City, town, or county) Pikesville Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE SEP 26 '60				25b. REGISTRAR'S SIGNATURE William S. Evans			

M

I



CERTIFICATE OF DEATH

Reg. Dist. No.

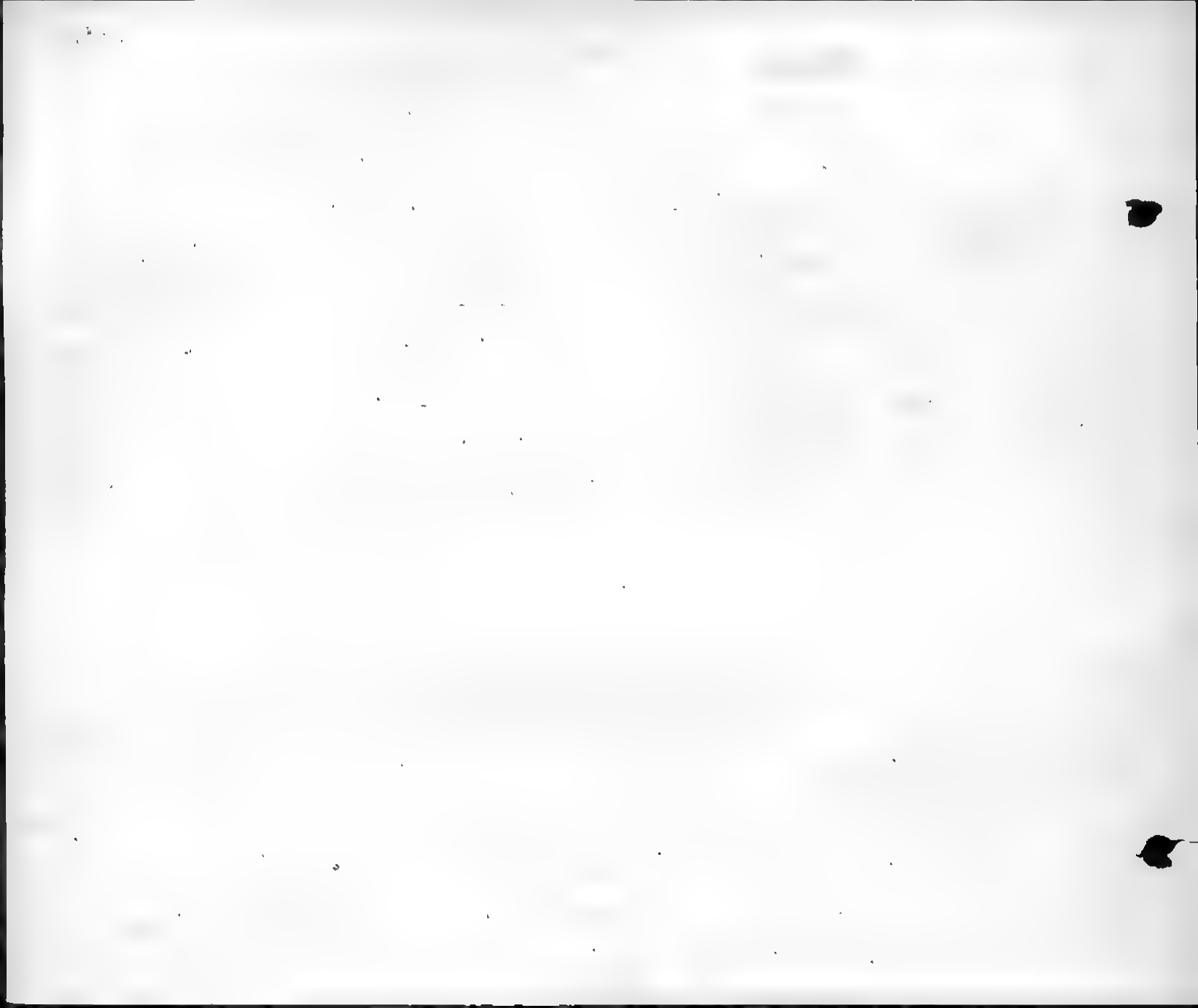
9916

9951

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>P</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2516 Joppa Road</i>		e. STREET ADDRESS <i>2516 Joppa Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Gertrude</i> Middle <i>Mary</i> Last <i>Plecker</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-16-1897</i>
9. AGE (In years last birthday) <i>62</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Patrick Sheridan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cowan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO <i>INFORMANT</i> <i>Samuel Plecker</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> 17 <i>17</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>carcinoma of ovary</i> (c) <i>18140</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18140</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>19</i> Hour a. m. <i>19</i> p. m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 6, 1959</i> to <i>Sept. 9, 1960</i> that I lost saw the deceased alive on <i>Sept. 6, 1960</i> and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. A. Grott</i>		ADDRESS (Street, city or town, state) <i>8100 Harford Rd. Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>H. A. GOTT, MD.</i>		DATE SIGNED <i>9/9/60</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>9-12-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 13 1960</i>	
ADDRESS <i>5305 Harford Rd.</i>		24b. REGISTRAR'S SIGNATURE <i>Walter S. Kuba</i>	

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

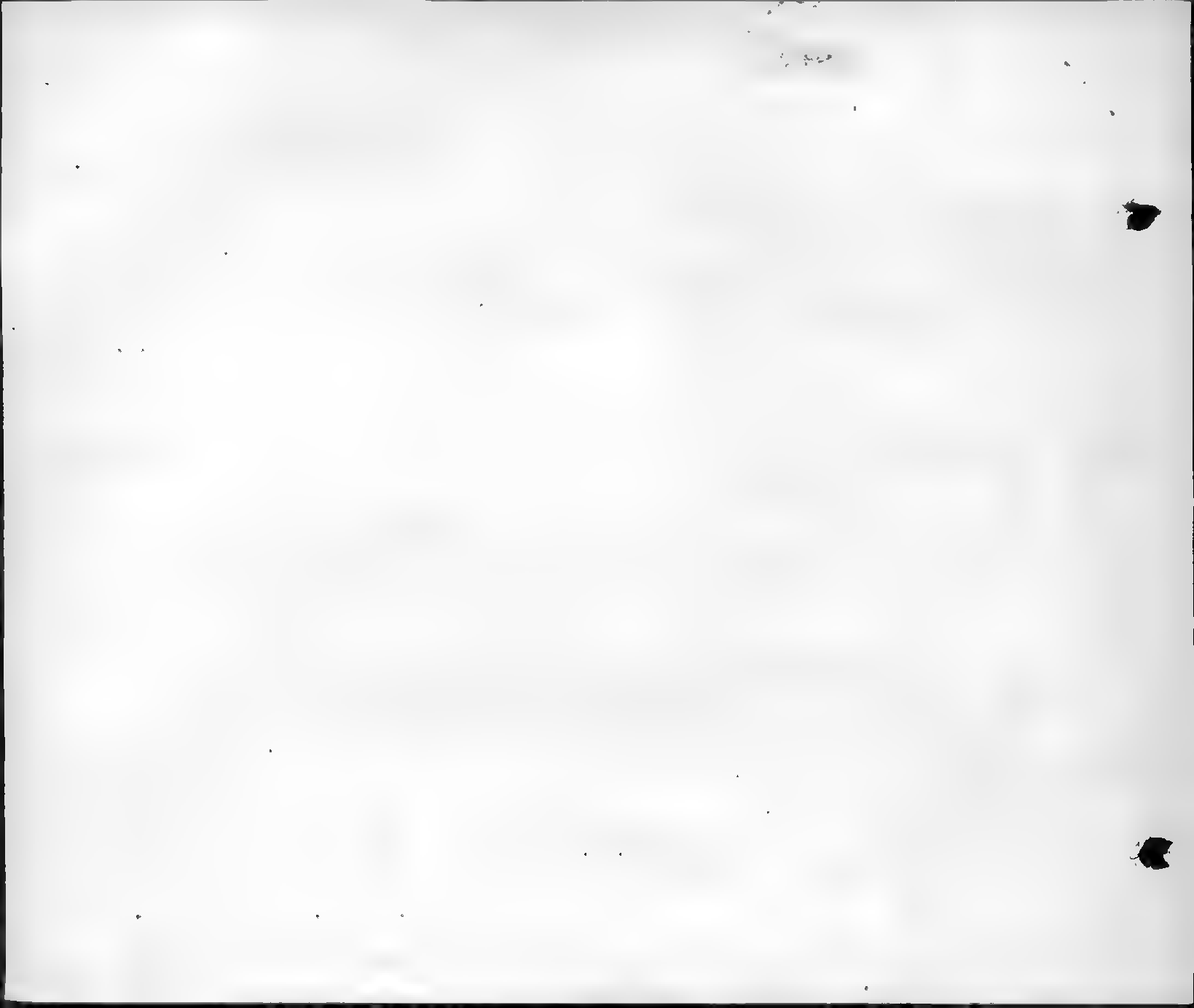
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
10052					10017				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2yr 1mth 27dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, Maryland (Edgewood, Md.)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 12			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Jane Last Poole			4. DATE OF DEATH Month September Day 5 Year 1960						
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1875		9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Albert Carico			14. MOTHER'S MAIDEN NAME Caroline Cox						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 8, 1958 to Sept. 5, 1960 , that (I) (we) last saw the deceased alive on Sept. 5, 1960 , and that death occurred at 8:20 p. M. from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar M.D.					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-6-60		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.					22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/60		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Cem.		23d. LOCATION (City, town, or county) (State) RD. Pel Air, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrying					25a. REC'D BY REGISTRAR SEP 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		



CERTIFICATE OF DEATH

10018

Reg. Dist. No.

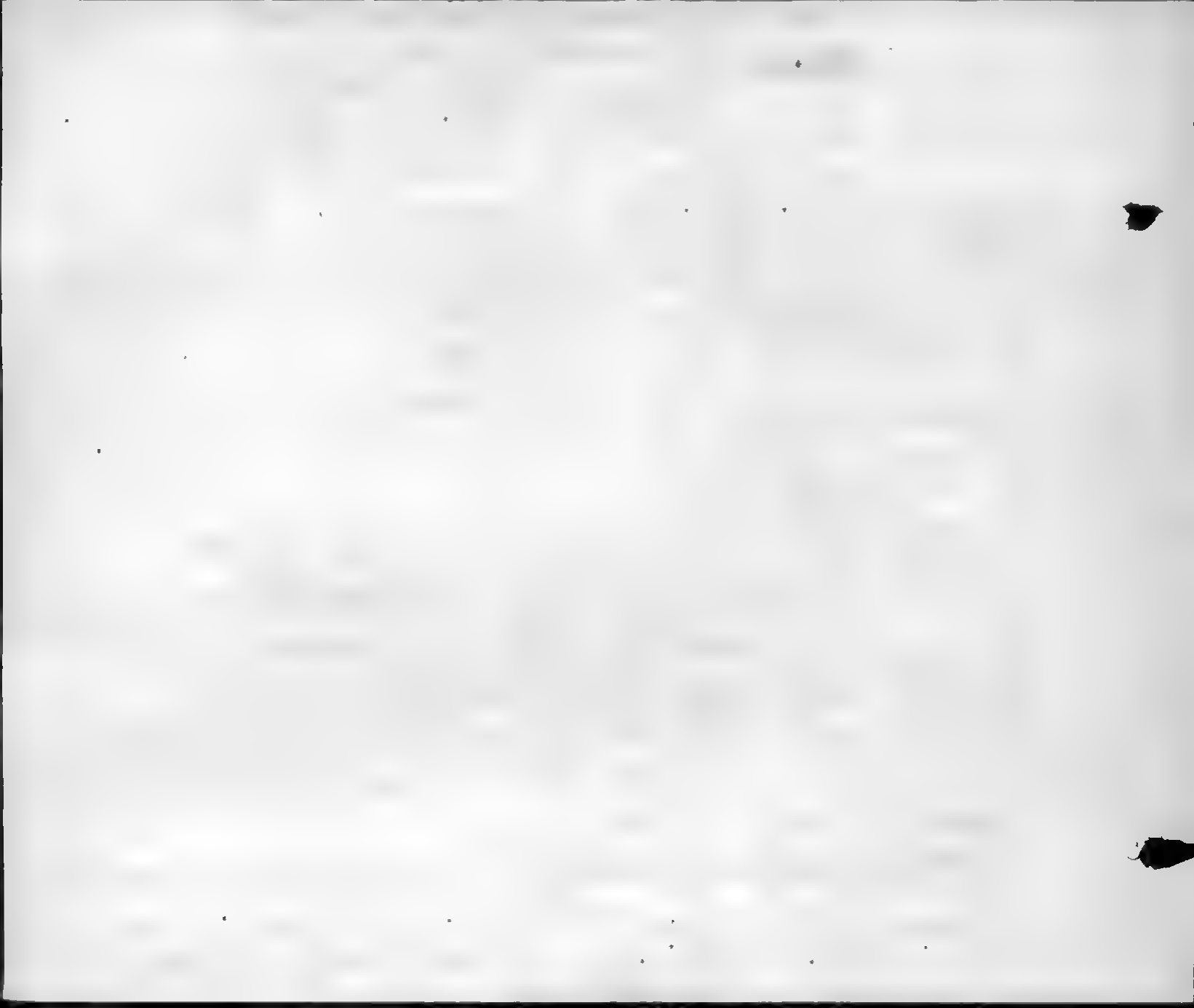
10053

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Riverside Dr. Balto. 21		d. STREET ADDRESS 209 Riverside Dr.	
3. NAME OF DECEASED (Type or print) AGATHA POWICHROSKI (POWICHROWSKI)		4. DATE OF DEATH September 26 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Baron		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Edward Powichroski 7955 Eastdale Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 29, 1934 , to Sept 26, 1960 , that I last saw the deceased alive on Sept 24, 1960 , and that death occurred at 1:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. Taylor Ave DATE SIGNED 9/27/60	
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D. Baltimore 21 2nd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/1960	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc.		24a. REC'D BY REGISTRAR DATE SEP 28 '60	
ADDRESS 401 S. Chester St.		24b. REGISTRAR'S SIGNATURE William P. H.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10054 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 1960 9-26060 et

CERTIFICATE OF DEATH

Reg. Dist. No.

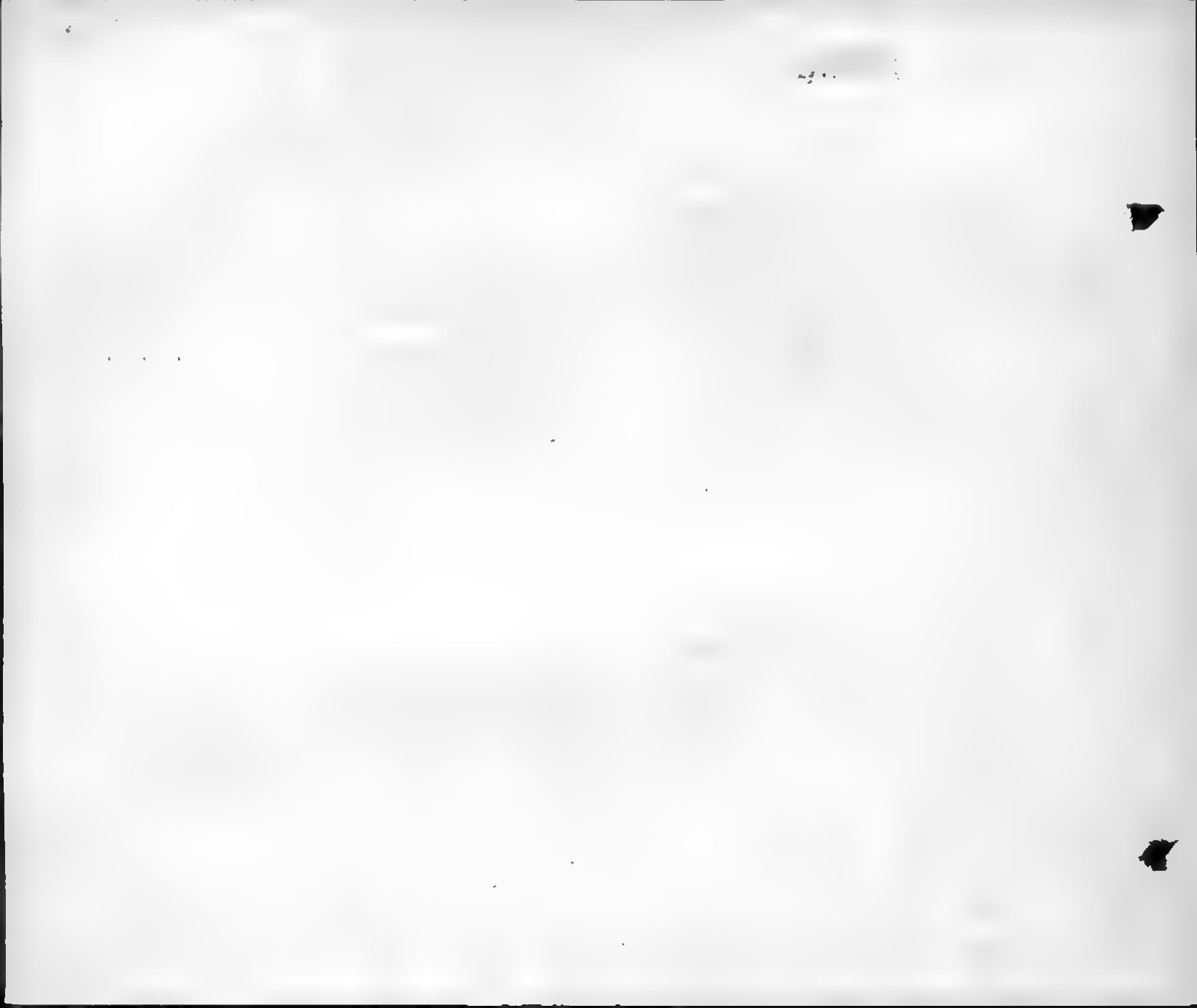
10019

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Warren Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>M.</i> Last <i>Price</i>		4. DATE OF DEATH Month <i>September</i> Day <i>14</i> Year <i>60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>14 October 1890</i>
9. AGE (In years last birthday) yrs. <i>69</i>		10. IF UNDER 1 YEAR IF UNDER 74 HRS Months <i>4</i> Days <i>22</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Sports Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Emory Price</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Wheeler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-3108</i>	
17. INFORMANT <i>Wife</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1950</i> to <i>September 1960</i> that I last saw the deceased alive on <i>13 September 1960</i> and that death occurred at <i>2 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Cockeysville 14 Sept 1960</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9-17-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>JESSOP CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>COCKEYSVILLE - MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Townson</i>		ADDRESS <i>York-RD-Townson</i>	
24a. REC'D BY REGISTRAR <i>SEP 16 60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fennell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Page 4 after death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

10056

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10021

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 9 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1209 DRUID HILL AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ROLAND Middle M Last PURVIANCE		4. DATE OF DEATH Month September Day 16 Year 19 60						
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT 8 1894	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS Days 66	Hours 66	Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY THEATER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME PETER PURVIANCE		14. MOTHER'S MAIDEN NAME HANNAH JANE JOHNSON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW-1 218-09-4451		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Chronic Renal Disease; Uremia; Electrolyte Imbalance; Possible Right Lung Tumor						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>						
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 7, 19 60 to September 16, 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 16, 19 60 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.								
22a. SIGNATURE Charles Allen, M.D. M.D.		22b. DATE SIGNED 9-17-60		22c. PHYSICIAN'S NAME (Type) Charles Allen, M.D.				
22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-21-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE HEMSLEY FUNERAL HOME 578 W BIDDLE ST BALTIMORE 1 MD				25a. REC'D BY REGISTRAR SEP 19 '60		25b. REGISTRAR'S SIGNATURE W. L. S. Thomas		



10057

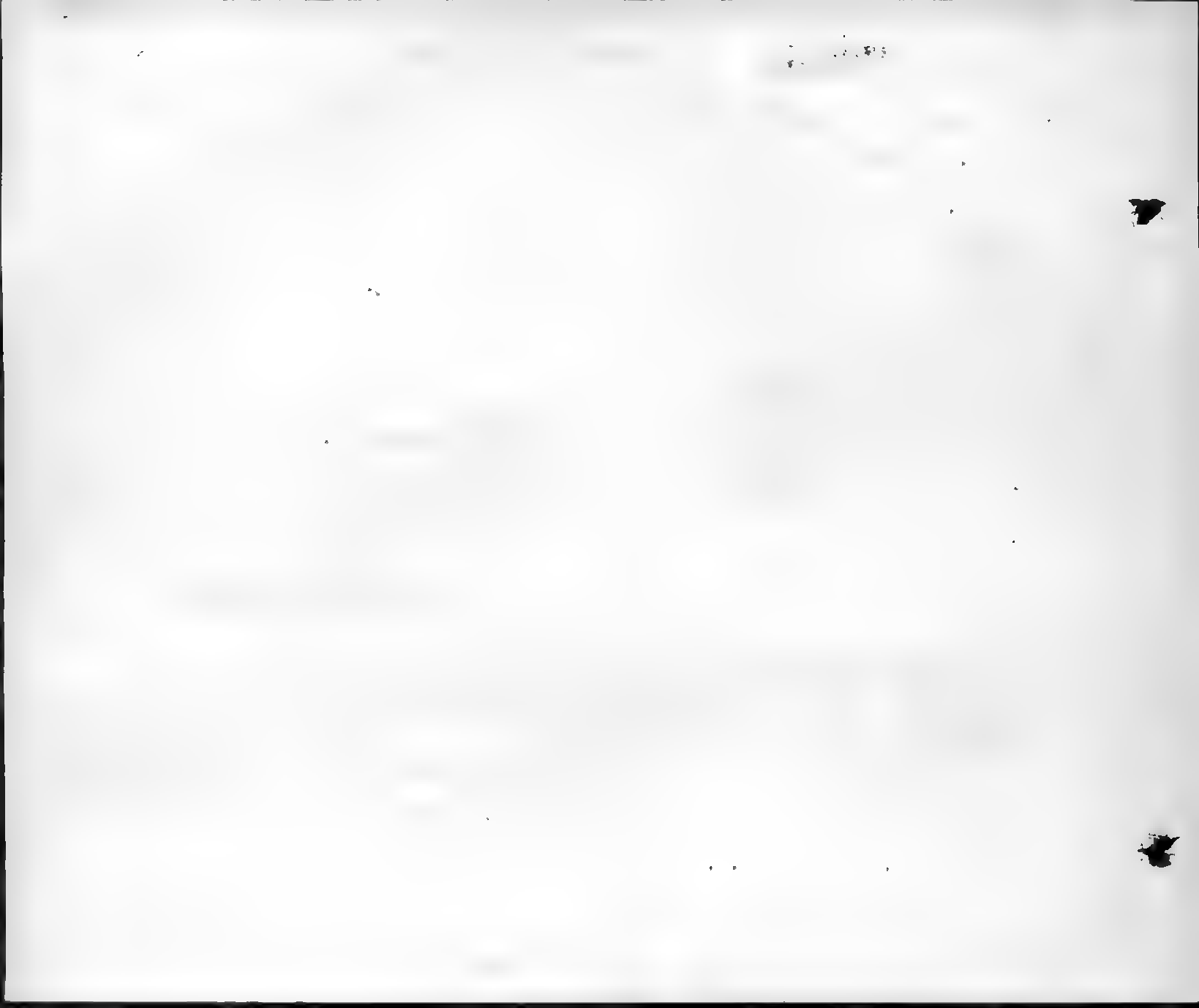
CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital			d. STREET ADDRESS 321 Hatt St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Edward Middle Pyle Last Pyle			4. DATE OF DEATH Month 9 Day 25 Year 1960		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1898	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building		
11. BIRTHPLACE (State or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Pyle			14. MOTHER'S MAIDEN NAME Julia Martin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-05-6057		
17. INFORMANT Hospital Records, Mt. Wilson State Hospital			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11/27, 1954 to 9/25, 1960 , that I last saw the deceased alive on 9/25, 1960 , and that death occurred at 10:40 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE William Newcomer			ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		
DATE SIGNED					
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/60		22c. NAME OF CEMETERY OR CREMATORY St. Paul	
22d. LOCATION (City, town, or county) Pylesville Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Pugh			ADDRESS Jessettville		
24a. REC'D BY REGISTRAR SEP 27 '60			24b. REGISTRAR'S SIGNATURE Arthur S. Kane		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, killed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10058

CERTIFICATE OF DEATH

10023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex 21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Homberg Ave.</u>		d. STREET ADDRESS <u>206 Homberg Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES RAYNER</u>		4. DATE OF DEATH Month Day Year <u>Sept. 26, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1888</u>
9. AGE (In years last birthday) yrs <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Ott</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-03-2593</u>	
17. INFORMANT <u>Helen Long</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <u>arteriosclerotic CardioVascular disease</u> DUE TO (c). <u>sudden</u> 5 yrs		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> to <u>9/26, 1960</u> , that I last saw the deceased alive on <u>9/26, 1960</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Baumgardner</u> M.D. <u>Balto 6 Md.</u>		ADDRESS (Street, city or town, state) <u>9/27/60</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. [unclear]</u>		ADDRESS <u>1407 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William P. [unclear]</u>	



CERTIFICATE OF DEATH

10024

Reg. Dist. No.

10059

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7909 Belair Rd.</u>		d. STREET ADDRESS <u>7927 Belair Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAGGIE</u> Middle <u>Reider</u> Last <u>Reider</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Besold</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Wildberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Millard Schilbach</u>		Address <u>2228 E. Madison St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> 4-1-1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Hypertensive Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>12 years</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY</u> , 19 <u>48</u> , to <u>SEPT. 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>SEPT. 26</u> , 19 <u>60</u> , and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Dussch</u>		M.D. <u>4636 Belair Road, Balt. 6, MD.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>9/27/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William E. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10026
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden</u> <u>51</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5007 Wilkins Ave.</u>				d. STREET ADDRESS <u>5007 Wilkins Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold L. Kieffer</u>				4. DATE OF DEATH Month Day Year <u>14</u> <u>14</u> <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1904</u>		9. AGE (in years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto./Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Reuschling</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Albright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>47-100</u>		17. INFORMANT <u>Annu M. Kieffer</u> Address <u>5007 Wilkins Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOWARD N. Hubbard</u>				ADDRESS <u>4707 Wilkins Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

DATE SIGNED
Sept. 14 1960

TO HC

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death. Page 4

by the funeral director,

should be filed within

10060

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10027

1. NAME OF DECEASED (Type or Print) EDWARD RHODE		2. DATE OF DEATH Sept. 5, 1960	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore County FULL NAME OF HOSPITAL OR INSTITUTION 608 Orpington Rd. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived if not in hospital or residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore - 29 D. STREET ADDRESS 608 Orpington Rd. (If rural, give location)	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 9, 1877
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (self emp.)		10B. KIND OF BUSINESS OR INDUSTRY Real Estate	9. AGE (In years last birthday) 82
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Martin Rhode		14. MOTHER'S MAIDEN NAME Margaretha Shuster	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dr. C. Martin Rhode - V.A. Hosp. Augusta, Ga.		ADDRESS	

ALL CERTIFICATION	18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease 42			10 yrs.
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST			
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22. I certify that (I) (this hospital) attended the deceased from Oct. 19 50 to Sept. 19 60 , that (I) was last saw the deceased alive on Sept. 2, 19 60 , and that in (my) (our) opinion death occurred at 11:45 A. from the causes and on the date stated above.				
23A. SIGNATURE Leo J. Caver ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23B. ADDRESS 1 Mallow Hill Ave., Baltimore 29, Md.		23C. DATE SIGNED 9/6/60
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/7/60	24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	24D. LOCATION (City, town or county) Woodlawn, Md.	(State)
25A. DATE REC'D BY HEALTH DEPT. SEP 7 60		25B. NAME OF REGISTRAR Arthur S. Haus		
		25C. FUNERAL DIRECTOR Wm. J. Pickens & Sons		

CERTIFICATE OF DEATH

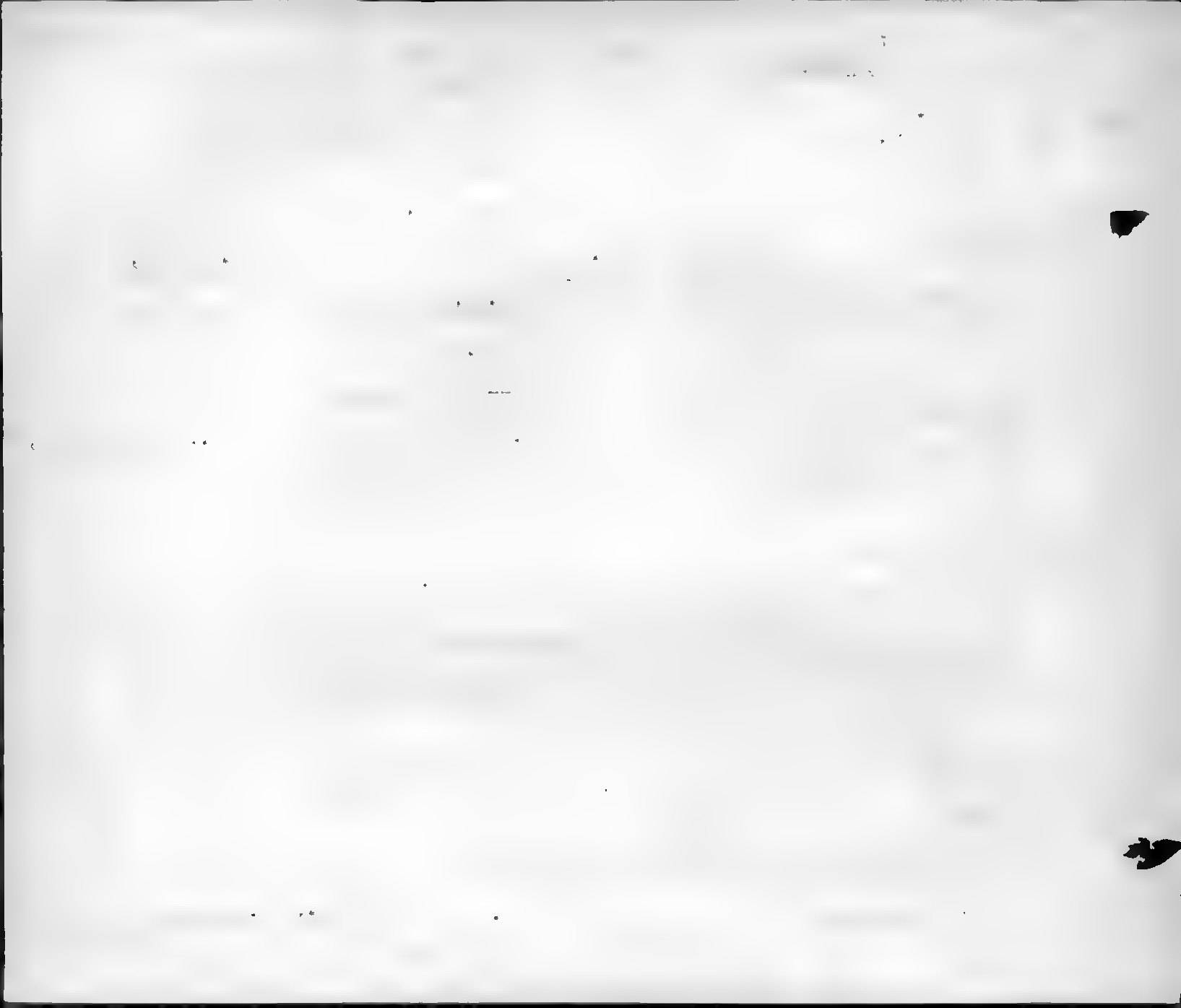
Reg. Dist. No. 10028

10061

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) b. COUNTY Md			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				d. STREET ADDRESS Warren Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last AIDA C. RICKETTS				4. DATE OF DEATH Month Day Year Sept. 7, 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1866	
9. AGE (In years last birthday) 93 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Roundtree							
13. FATHER'S NAME David Ricketts				14. MOTHER'S MAIDEN NAME Roundtree			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Mary Ricketts - Warren Rd., Cockeysville, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Small Strokes 422.2 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Degenerative Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/18/60 to 9/7/60 that I last saw the deceased alive on 9/6/60 , at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Fredrick Rd Catonsville 28md DATE SIGNED 9/7/60							
ACTUAL SIGNATURE W. E. McGrath				M.D. 1303 Fredrick Rd Catonsville 28md			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/1960		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Becker & Sons - Balto				24a. REC'D BY REGISTRAR SEP 13		24b. REGISTRAR'S SIGNATURE W. J. Becker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10062

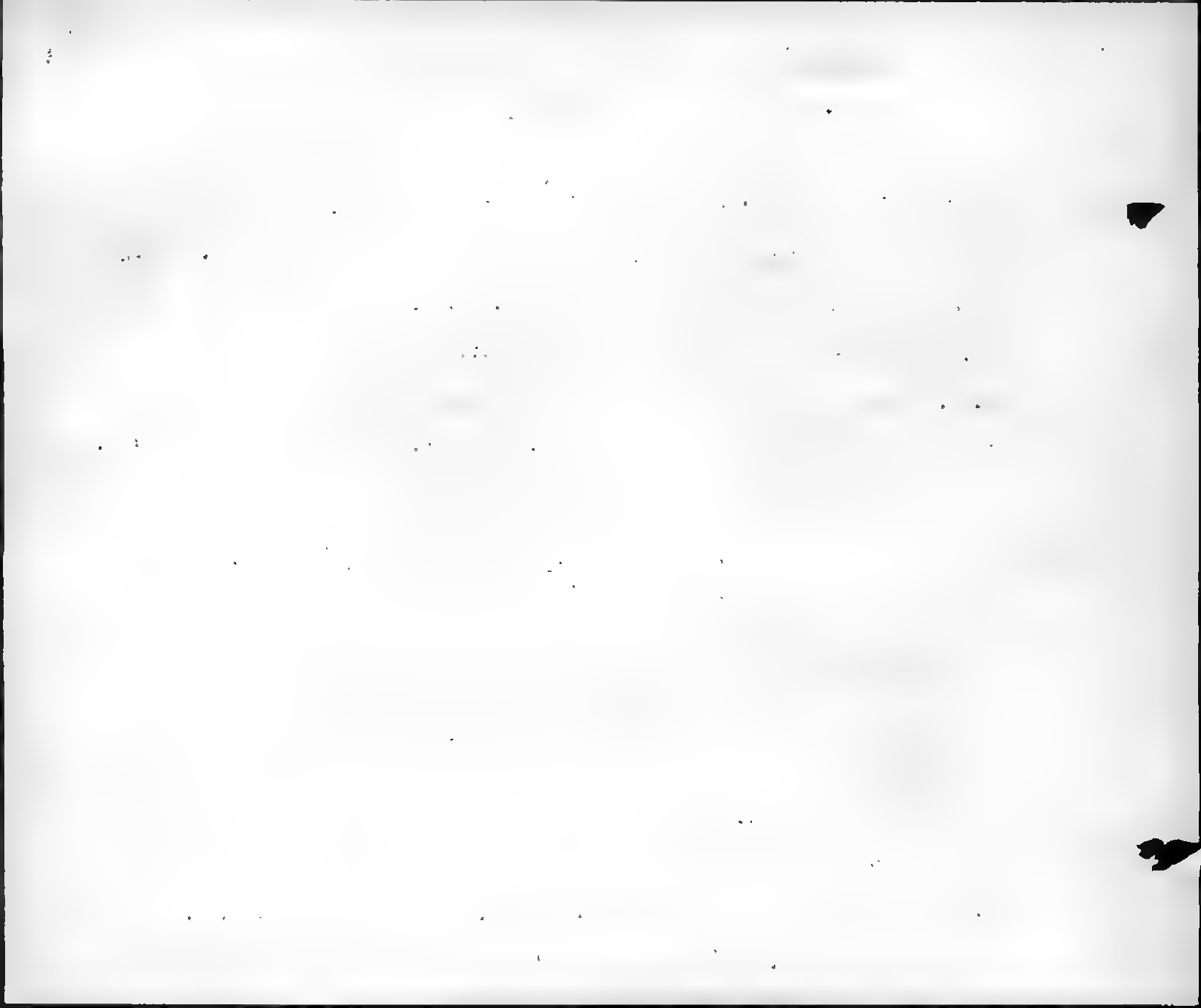
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) p. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON Convalescent Ho. 301 Chesapeake				d. STREET ADDRESS 1425 Winston Ave.			
3. NAME OF DECEASED (Type or print) First HENRY Middle LEWIS Last RIECKS				4. DATE OF DEATH Month Sept. Day 20 Year 1960			
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Warehouse		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Liquor		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. H. Riecks				14. MOTHER'S MAIDEN NAME Katarina Leypoldt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		INFORMANT Mr. Edward H. Riecks - 1425 Winston Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Virus infection & Pneumonia 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia - cerebral atrophic sclerosis DUE TO hypertensive sclerosis of brain (c) hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 55 , to Sept 20 1960 , that I last saw the deceased alive on Sept 20 , 19 60 and that death occurred at 10:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3033 W North A DATE SIGNED Balto IC MD							
ACTUAL SIGNATURE James B. Byrd		M.D. 3033 W North A		DATE SIGNED Balto IC MD			
PHYSICIAN'S NAME (Type) M Paul Tibbels							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/60		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lasker				ADDRESS 1425 Winston Ave.		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



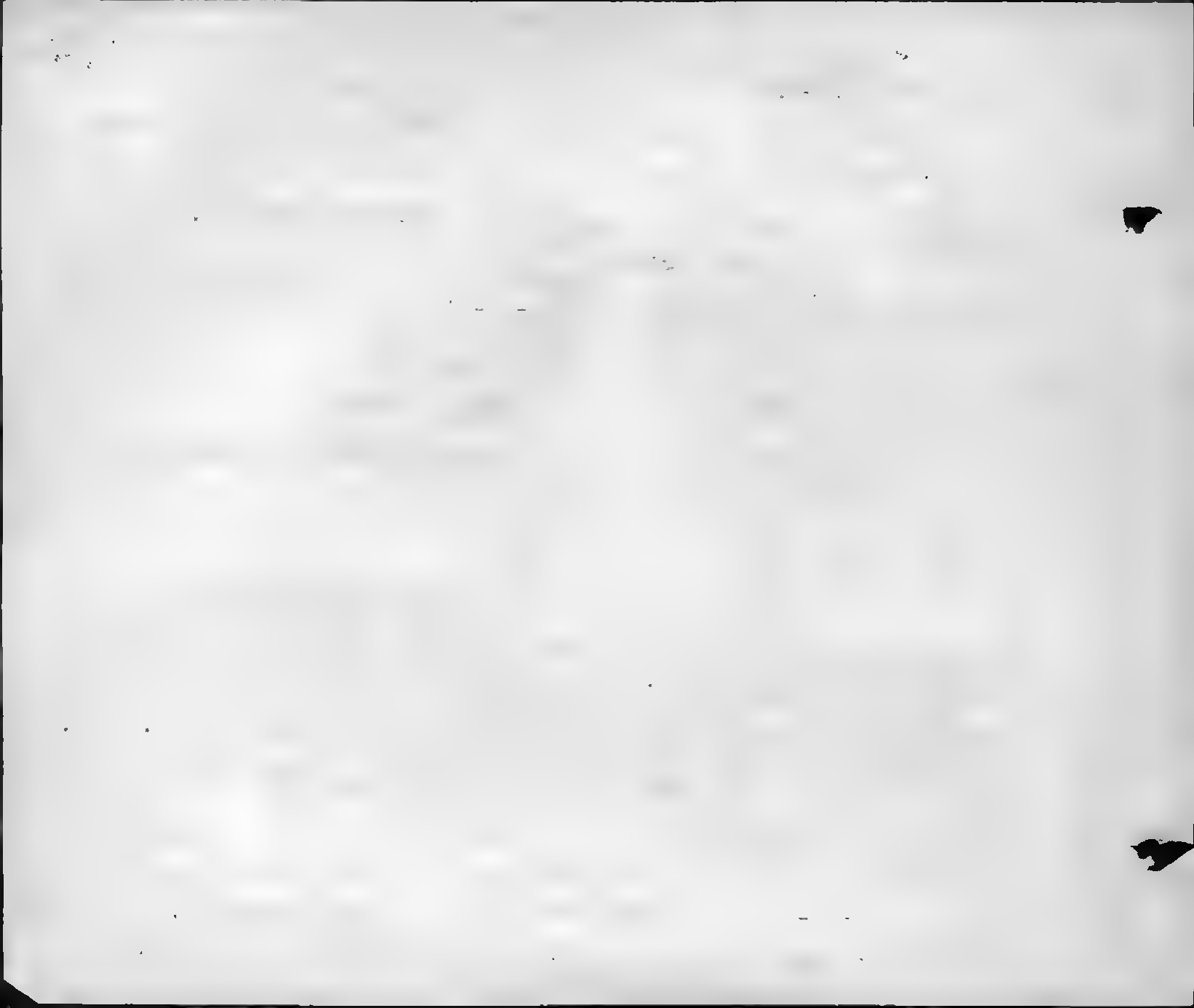
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY 9948		2. USUAL RESIDENCE (Where deceased lived, if instit' on, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 2802 Hollins Ferry Rd.	
3. NAME OF DECEASED (Type or print) RICHARD DOUGLAS RINGROSE		4. DATE OF DEATH September 13 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-51	
9. AGE (In years, if under 1 year, Months, Days; if under 24 hours, Hours, Min.) 9 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melvin Ringrose		14. MOTHER'S MAIDEN NAME Daisy Newsome	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Melvin Ringrose		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning			
929.8 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned.			
20c. TIME OF INJURY Month, Day, Year 8:15 P.m. 9/13/60			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) water			
20f. (City or town) (County) (State) Baltimore Balto. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. Spence M.D.			
EXAMINER'S NAME (Type) Wm. Spence			
22a. BURIAL, CREMATION REMOVAL (Specify) burial			
22b. DATE THEREOF 9-17-60			
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			
22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR Leonard J. Ruck			
ADDRESS 5305 Harford Rd.			
24a. REC'D BY REG. STRAR SEP 16 '60			
24b. REG. STRAR'S SIGNATURE Arthur S. Knaus			



CERTIFICATE OF DEATH

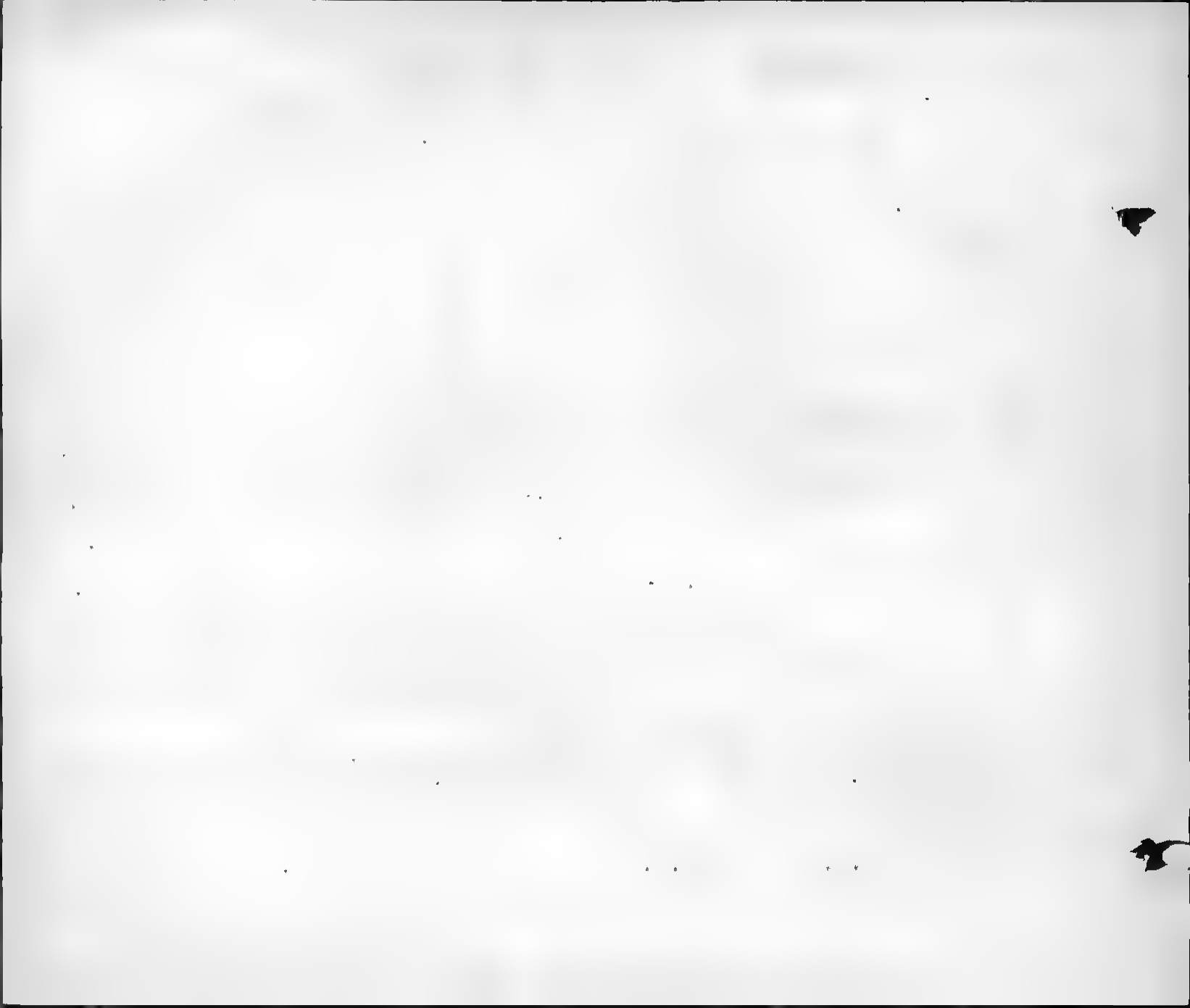
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN 1b <i>Catonville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>137 Wesley Ave.</i>		d. STREET ADDRESS <i>137 Wesley Ave.</i>	
3 NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>A</i> Last <i>Russ</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>17</i> Year <i>1960</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 1, 1892</i>
9. AGE (In years last birthday) <i>68</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Howard Co., Md.</i>	
11 BIRTHPLACE (State or foreign country) <i>Howard Co., Md.</i>		12 CITIZEN OF WHAT COUNTRY	
13 FATHER'S NAME <i>John Queen</i>		14. MOTHER'S MAIDEN NAME <i>Mary F. Barbour</i>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16 SOCIAL SECURITY NO <i>528-44-5680</i>	
17. INFORMANT <i>Grace E. Brown</i>		Address <i>Some</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>526X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchiectasis</i> DUE TO (c) <i>Chr. Bronchitis</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arterio sclerosis</i>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 3rd</i> , 19 <i>60</i> , to <i>Sept. 17</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Sept. 17</i> , 19 <i>60</i> , and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>C. F. Maloney MD</i>		ADDRESS (Street, city or town, state) <i>57 Winters Lane</i>	
PHYSICIAN'S NAME (Type) <i>C. F. Maloney, D.O.</i>		DATE SIGNED <i>9/17/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ARLINGTON S. PHILLIPS</i>		ADDRESS <i>1808 N. Monroe St.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 22 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

M

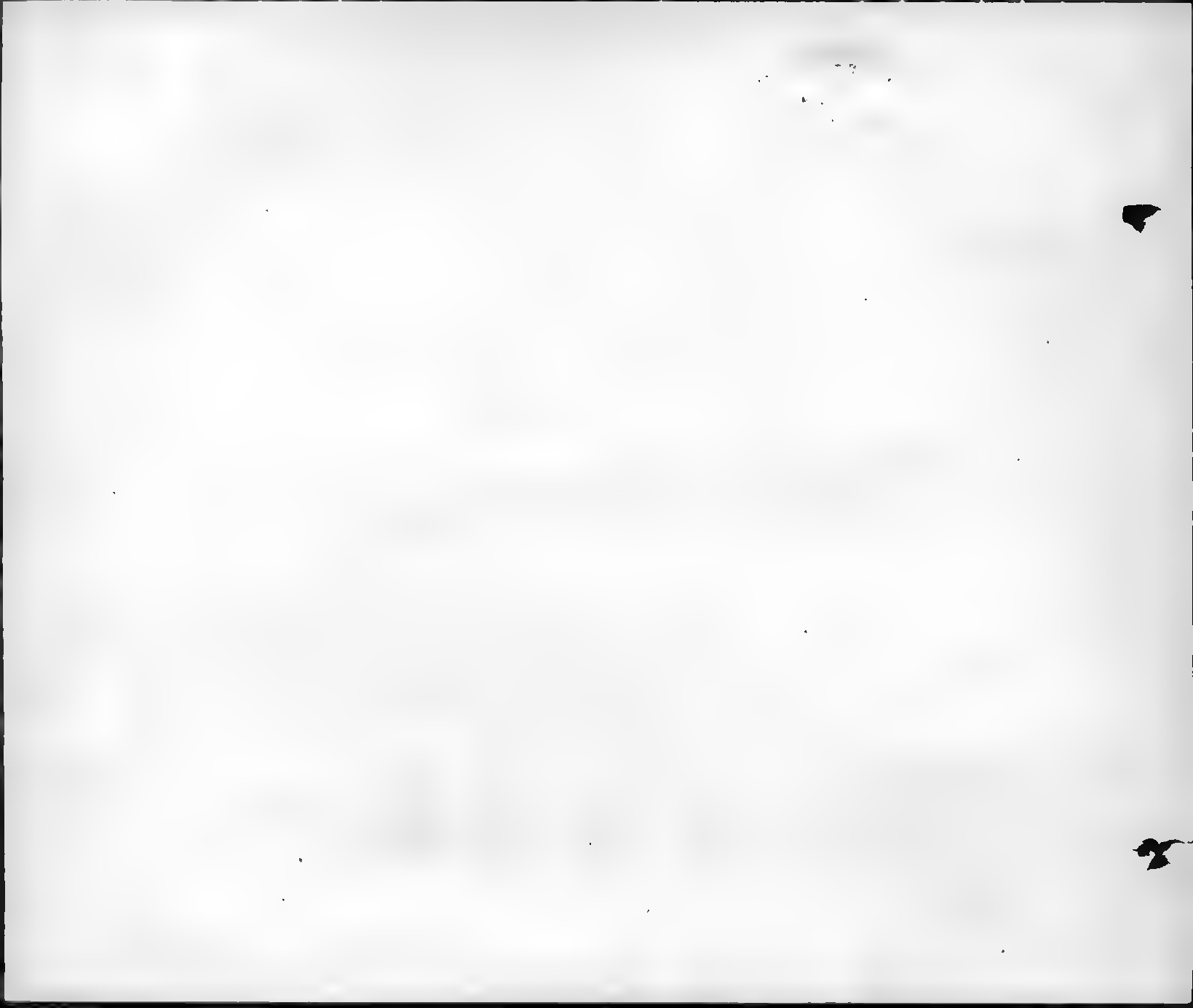
1

10063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10032

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COLLEGE MANOR HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MODMAN</u> First <u>Grace</u> Middle <u>Seaton</u> Last <u>Seaton</u>				4. DATE OF DEATH <u>Sept 4</u> Month <u>1960</u> Day <u>19</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Seander Seaton</u>				14. MOTHER'S MAIDEN NAME <u>Jeno V. Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. R. Steiner</u> Address <u>5219 Putney Way</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute cardiac decompensation</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> <u>5 yrs</u>							
(c) <u>General Arteriosclerosis</u> <u>10 yrs</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1957</u> to <u>Sept 4</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>60</u> and that death occurred at <u>5</u> P. M. from the causes and on the date stated above							
22a. SIGNATURE <u>A.S. Chalfant</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u>				22d. ADDRESS <u>6216 YORK Rd. Baltimore 12</u>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Sept 6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Richfield Springs New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Linn</u> ADDRESS <u>4210 Gilman Road</u>				25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>William L. Linn</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

M

1

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10034

Items 7, 9, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Co. Dispensary		e. STATE Maryland		f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere	
3. NAME OF DECEASED (Type or print) WALTER RYAN (RYNAZEWSKI)		4. DATE OF DEATH September 20 19 60		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH May 2, 1906		9. AGE (In years last birthday) Age: 54		10. AGE (In years last birthday) 54-56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth. Steel Co.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Rynazewski		14. MOTHER'S MAIDEN NAME Agnes Kamosinski		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War 11		16. SOCIAL SECURITY NO.		17. INFORMANT Alice Ryan Box 68 Edgemere Md. Rt. 10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ANNUAL SIGNATURE Charles S. Petty		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)		DATE SIGNED 9/20/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nation Cemetery	
22d. LOCATION (City, town, or country) (State) Frederick Ave Balto., Md		23. FUNERAL DIRECTOR LEO G. COOK 1701 PATTERSON PK. AVE.		24a. REC'D BY REGISTRAR SEP 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

33-33

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

10066

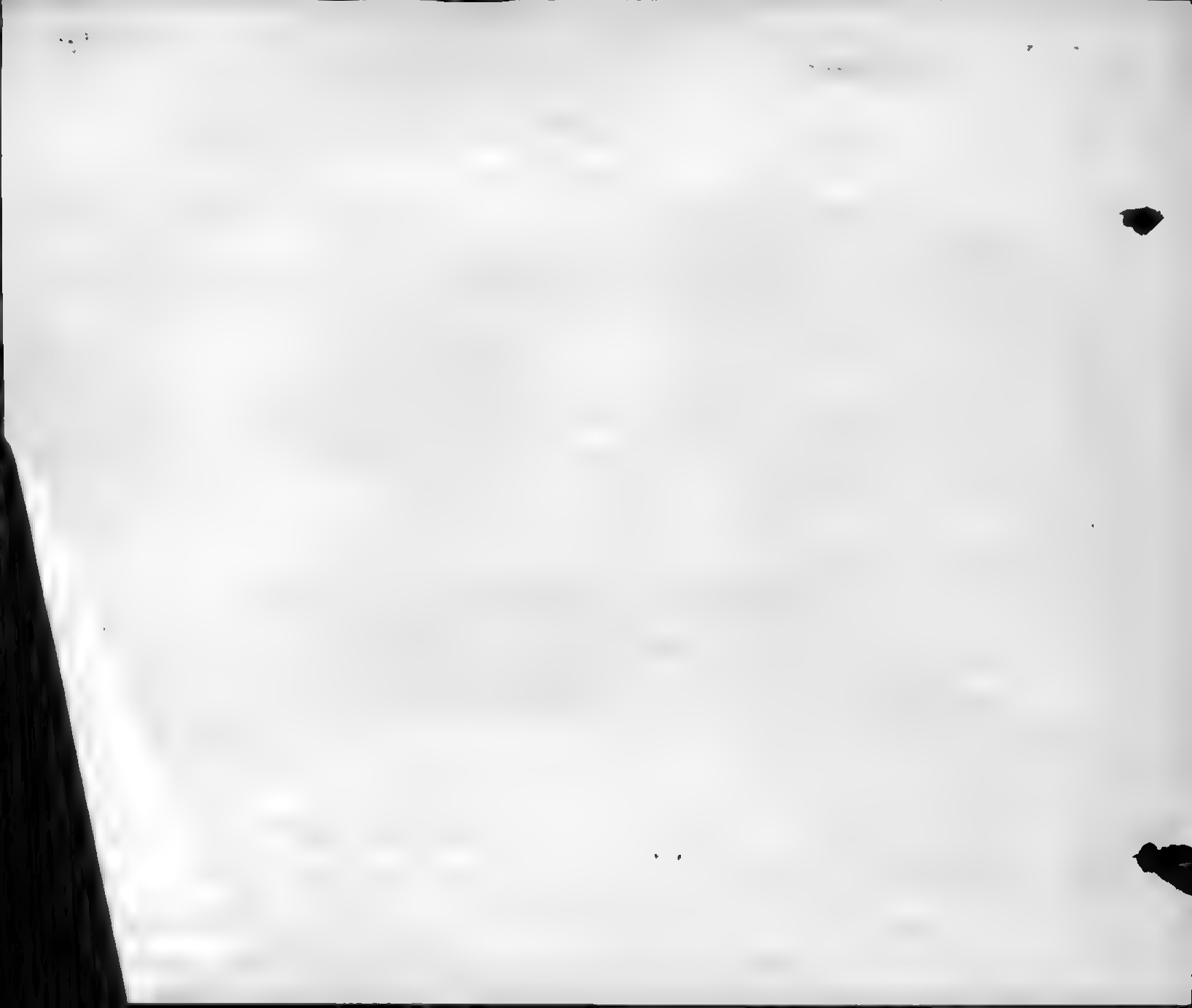
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3415 Sellers Point Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 3415 Sellers Point Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LORRAINE DORIS SANCHEZ				4. DATE OF DEATH September 26, 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/35	
9. AGE (In years last birthday) 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Siegai				14. MOTHER'S MAIDEN NAME Clairine Wehr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Juan T. Sanchez				Address 3415 Sellers Pt. Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE P. W. Reel				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Peter Rieckert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. Associate Pathologist X			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/29/60		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR Philip Herwig Sons		ADDRESS 2024 Orleans St		24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGIS'	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10067

10036

(M)

514

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 18yr5mth14dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2318 E. Hoffman Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Sauerland Last				4. DATE OF DEATH Month September Day 12 Year 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1876		9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1960 to Sept. 12, 1960 , that (I) (we) last saw the deceased alive on Sept. 12, 1960 , and that death occurred at 2:00 p. M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 9-13-60		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/28/60	23c. NAME OF CEMETERY OR CREMATORY H. P. P. Co.		23d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. H. H. Co. - 28				25a. REC'D BY REGISTRAR DATE SEP 29 60		25b. REGISTRAR'S SIGNATURE Arthur L. Kinner	



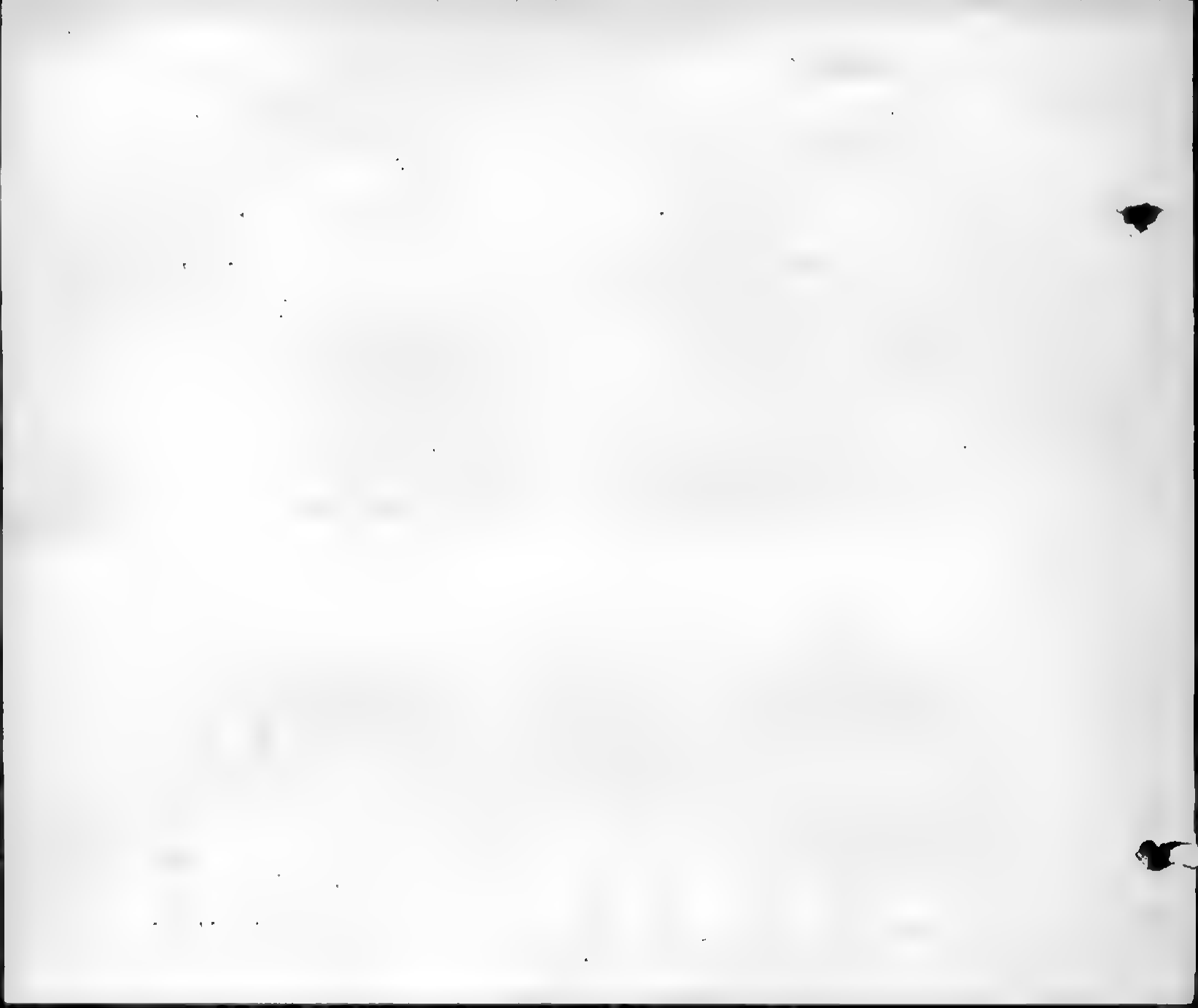
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10037

10068

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 701 Christian Ave.		d. STREET ADDRESS 701 Christian Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Lillian Scharmer		4. DATE OF DEATH Month Day Year Sept. 18, 1960	
5. SEX Female	6. COLOR or RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Mahler		14. MOTHER'S MAIDEN NAME Anna Szabadsag	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank Scharmer		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory failure DUE TO (b) Bronchopneumonia, bilateral DUE TO (c) Cancer of the lower abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition due to cancer.			
INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 days 6 to 12 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 3/26 60 to 9/18 60	
21. I certify that (I) (this hospital) attended the deceased from 3/26 60 to 9/18 60 , that (I) (we) last saw the deceased alive on 9/18 60 , and that death occurred at 5 P.M. from the causes and on the date stated above			
22a. SIGNATURE Eugene C. Baumann		22b. DATE SIGNED 9/19/60	
22c. PHYSICIAN'S NAME (Type) Eugene C. Baumann		22d. ADDRESS 413 Eastern Ave., Baltimore 21, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James Bruzdzinski		25a. REC'D BY REGISTRAR DATE SEP 20 '60	
ADDRESS 1407 Eastern Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

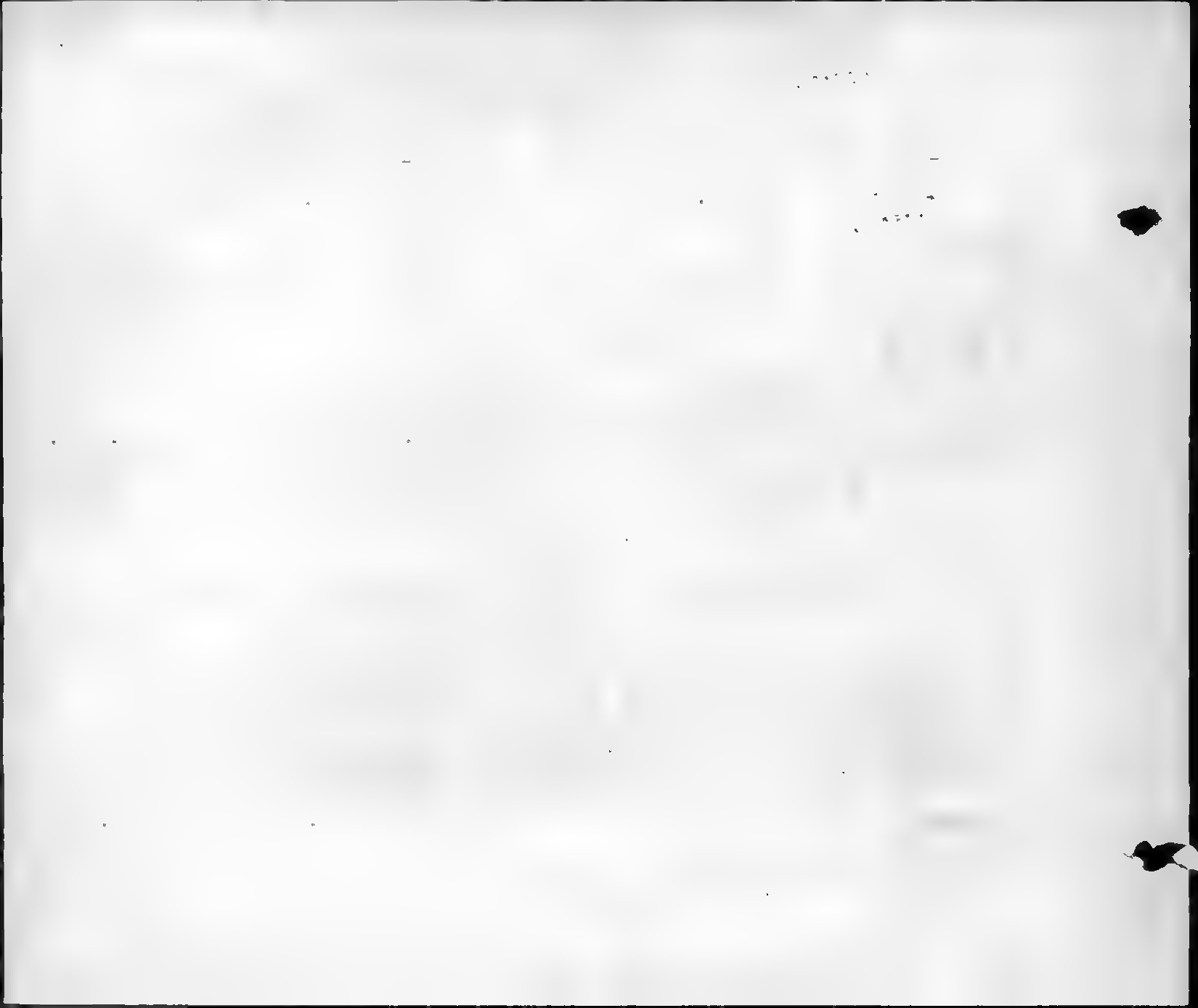
10069 CERTIFICATE OF DEATH

10038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>			c. LENGTH OF STAY IN lb <u>11 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural -- Randallstown</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3306 Offutt Rd.</u>				d. STREET ADDRESS <u>3306 Offutt Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Henry</u> Middle <u>Schmidt</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1960</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-7-1880</u>		9. AGE (In years lost birthday) <u>79</u> yrs <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gardener</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>John Henry Schmidt</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Kennell</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>218-32-6253</u>		17. INFORMANT <u>Wife -- Mrs. Mary Schmidt, Offutt Rd. Rand.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>35 years</u> </div> </div>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>6-10-</u> , 19 <u>59</u> , to <u>9-14-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-13</u> , 19 <u>60</u> , and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> </div> <div style="width: 50%;"> ADDRESS (Street, city or town, state) <u>8204 Liberty Rd. Baltimore 7, Md.</u> </div> </div> DATE SIGNED <u>Edwin L. Pierpont, M.D.</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harrison, Md.</u>										
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin L. Pierpont</u>						24a. REGD. BY REGISTRAR <u>SEP 16 60</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Krump</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10040

10070

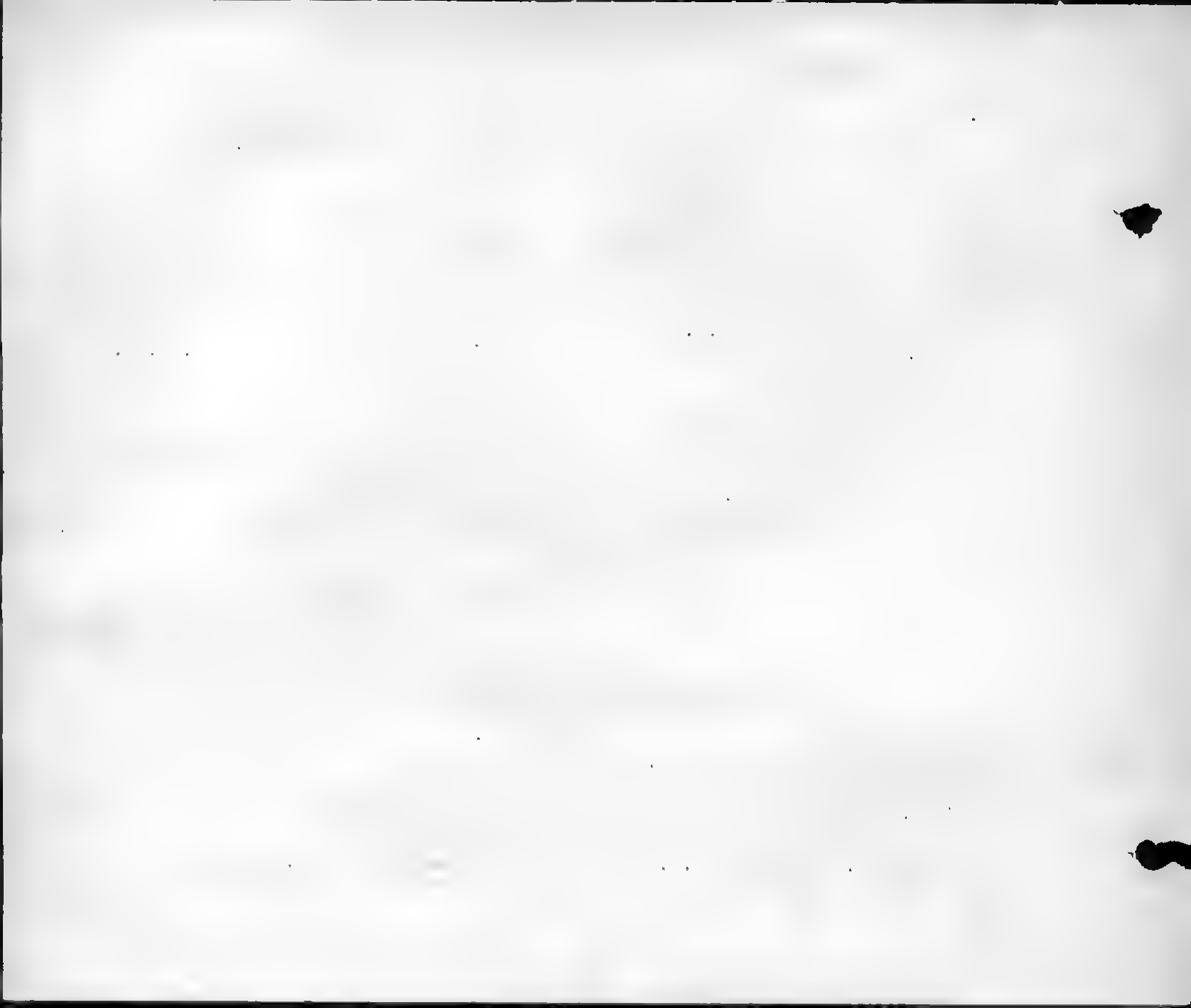
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 80 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Texas b. COUNTY Bexar c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Antonio d. STREET ADDRESS 237 Escalon Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Served LOUISE First LOUISE Middle IRENE Last NEILL SCHULTZ)				4. DATE OF DEATH Month September Day 27 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1909	
9. AGE (in years last birthday) 51 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Clerk-typist		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oscar T. Schultz				14. MOTHER'S MAIDEN NAME Irene Throop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 325-01-5008		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT BREAST WITH (TOTAL MASTECTOMY 1950) WITH GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170x (b) CACHEXIA DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH 10 YEARS 4 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from July 9 10:30 to September 27, 60 that (Y) (we) last saw the deceased alive on September 19, 60 and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE SIGNED 9/27/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/25/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Sanders & Sons, Inc. North Ave. & Broadway				25a. REC'D BY REGISTRAR SEP 29 '60		25b. REGISTRAR'S SIGNATURE William S. Kram	
Baltimore, Md.							

MEDICAL CERTIFICATION

2

M

059



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10041

10071

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>15 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5743 Edmondson Ave Kedgewood Nursing Home</u>				d. STREET ADDRESS <u>10071</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>SENEY</u> Last <u>SENEY</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 - 1872</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hauswirth</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Kimble</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rebecca ?</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Name <u>George E Senev</u> Address <u>3634 Elmdale Ave Balt. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Sept. 11</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>60</u> and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>D. C. MacLaughlin</u>				22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>	
22d. ADDRESS <u>4508 Edmondson Village Baltimore 22, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 13 - 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Cherry Hill Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Barton of Eastern Star Centerville Md</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>James S. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Padonia Road						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville d. STREET ADDRESS 203 Padonia Road e. IS RESIDENCE <input checked="" type="checkbox"/> A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MOLLIE ELIZABETH Saffell First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 13, 1880 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 79 yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? USA						4. DATE OF DEATH September 13, 1960 Month Day Year 13. FATHER'S NAME Clayton Fry 14. MOTHER'S MAIDEN NAME Jane Campbell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 16. SOCIAL SECURITY NO. None 17. INFORMANT Family Records Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) Myocarditis - Decompensating (c) Hypertension - arteriosclerotic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1-1-1960 to 9-13-60 that (I) (we) last saw the deceased alive on 9-13-60 and that death occurred on 9-13-60 M, from the causes and on the date stated above.											
22a. SIGNATURE James G. Saffell M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) James G. Saffell 22d. ADDRESS Reisterstown, Md						22b. DATE SIGNED 9-13-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 17, 1960 23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cem 23d. LOCATION (City, town, or county) Cockeysville, Maryland				24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland 25a. REC'D BY REGISTRAR DATE SEP 16 '60 25b. REGISTRAR'S SIGNATURE C. L. King & Sons							



STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10043

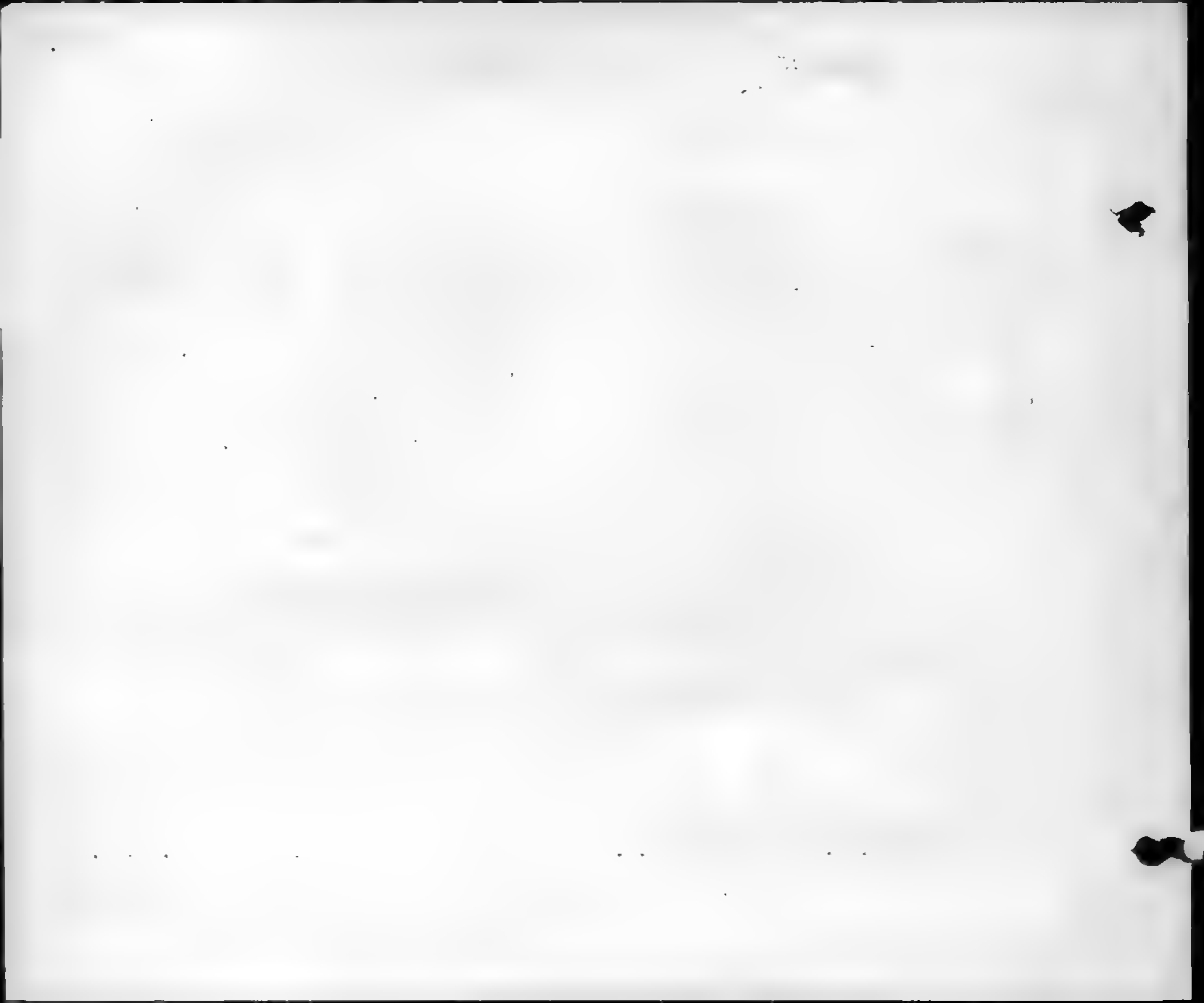
10073

CERTIFICATE OF DEATH

Item 1 filled in 9-22-60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit during the Whitewood Ave</u>		d. STREET ADDRESS <u>619 Southmont Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Smart</u> Last <u>L</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hampstead, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>W. S. R.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>George Lee</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Robert L. Smart-son</u>		Address <u>619 Southmont Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X Acute Pulmonary Edema</u> DUE TO (b) <u>Anterior Chute C.V. Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>April 1955</u> to <u>Sept 14 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 13 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Denise Langlin</u>		22b. DATE SIGNED <u>Sept. 15 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. Langlin, M.D.</u>		22d. ADDRESS <u>4500 ... on ...</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 17 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. 7. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. ...</u>	
ADDRESS <u>4101 Edmondson Ave</u>		DATE <u>SEP 16 '60</u>	

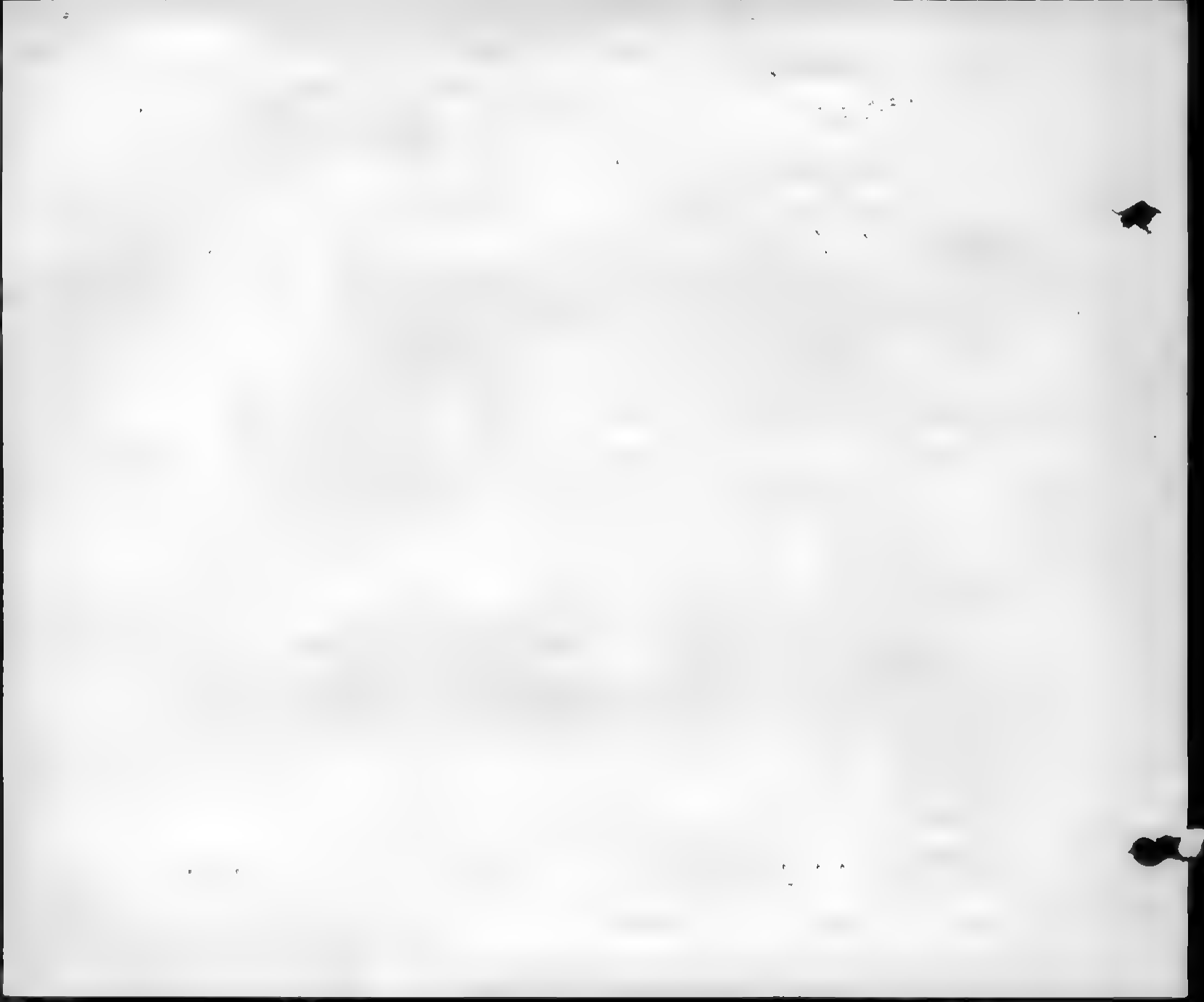


TO DEPENDENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 10044									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY in 1b 3mo. 13		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sspring Grove State Hosp/					d. STREET ADDRESS Cockesville Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Washington First Middle Waddell Wellington-Smith					4. DATE OF DEATH Month Sept. Day 9, Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-1871		9. AGE (In years last birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown Smith					14. MOTHER'S MAIDEN NAME Not Known				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. no		17. INFORMANT Record Of Hospital			Address Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary thrombosis 104.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Fracture right femur (accidental) by fall on floor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on floor						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Balto. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Geo. S. M. Kieffer M/D					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M/D					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 10, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept. 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Immanuel Church Cem.			22d. LOCATION (City, town, or county) (State) Glencoe, Balto. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Son, Towson, Md.					24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hearn		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

M

9949

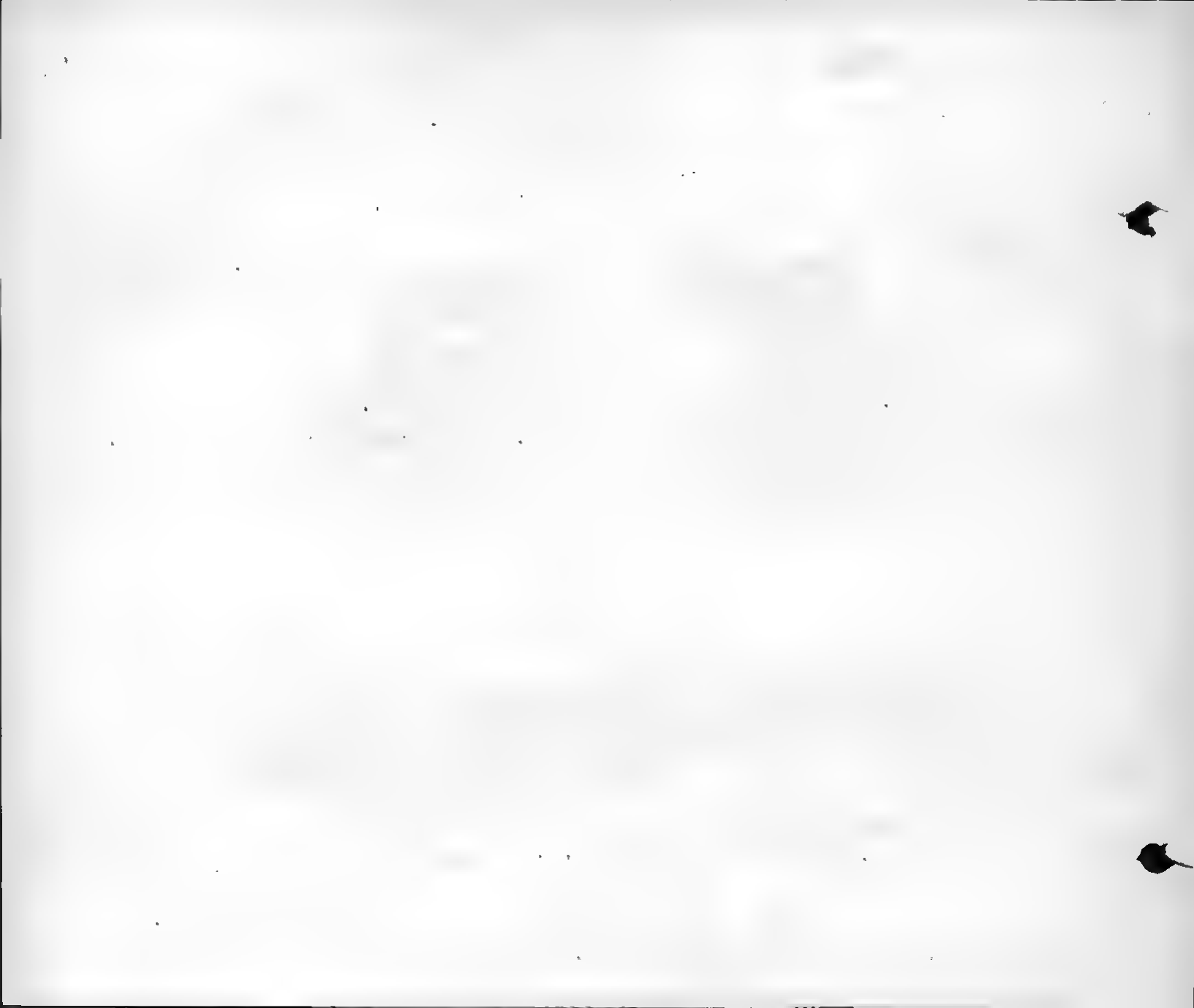
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10045

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Relay				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 612 Gun Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Viola Sonnenberg				4. DATE OF DEATH Month Day Year Sept. 19 1960 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1884		9. AGE (in years lost birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Elmer E. Read				14. MOTHER'S MAIDEN NAME Sarah L. Shannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Eleanor Clayton 612 Gun Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) 4 + x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 1958 to Sept 17 1960 that (I) (we) last saw the deceased alive on Sept 17 1960 and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. Bradley Daugharthy, M.D. M.D.				22b. DATE SIGNED 9-22-60			
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M.D.				22d. ADDRESS 1111 Folsom Ave Baltimore Md			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.				25a. REC'D BY REGISTRAR DATE SEP 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

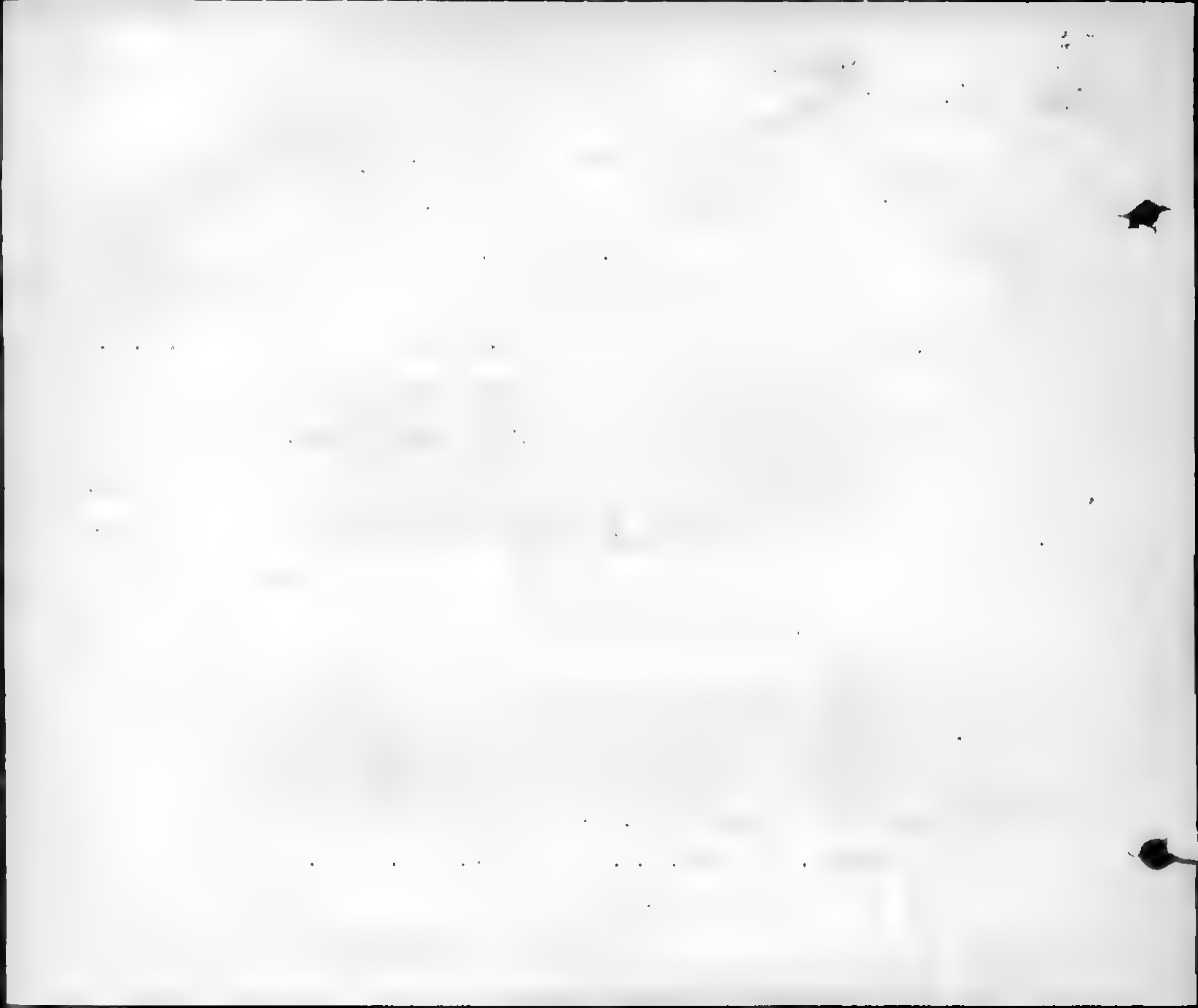
10075

10046

1. PLACE OF DEATH County Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (25)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4020 Eighth Street 3VC1-7	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last SOPER		4. DATE OF DEATH Month September Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 11, 1920
9. AGE (in years last birthday) 40 yrs		10. IF UNDER 1 YEAR Months 40 Days 14 Hours 10 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Paper Box Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George H. Soper		14. MOTHER'S MAIDEN NAME Mabel Swift	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW II		16. SOCIAL SECURITY NO 213-10-9310	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md.		Address FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 453.1 IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLISMS DUE TO MARKED CARDIOMEGLAY WITH CARDIAC DECOMPENSATION X AND ANASARCA DUE TO BUERGER'S DISEASE DUE TO SURGICAL AMPUTATION CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation Amputation both legs 11/4/57			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNKNOWN 2Yrs. 10 MO/
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 12:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from September 6, 1960 to Sept. 22, 1960 , that (X) (we) last saw the deceased alive on Sept. 22, 1960 , and that death occurred at A/M , from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE 9/22/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully		25a. REC'D BY REGISTRAR SEP 26 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



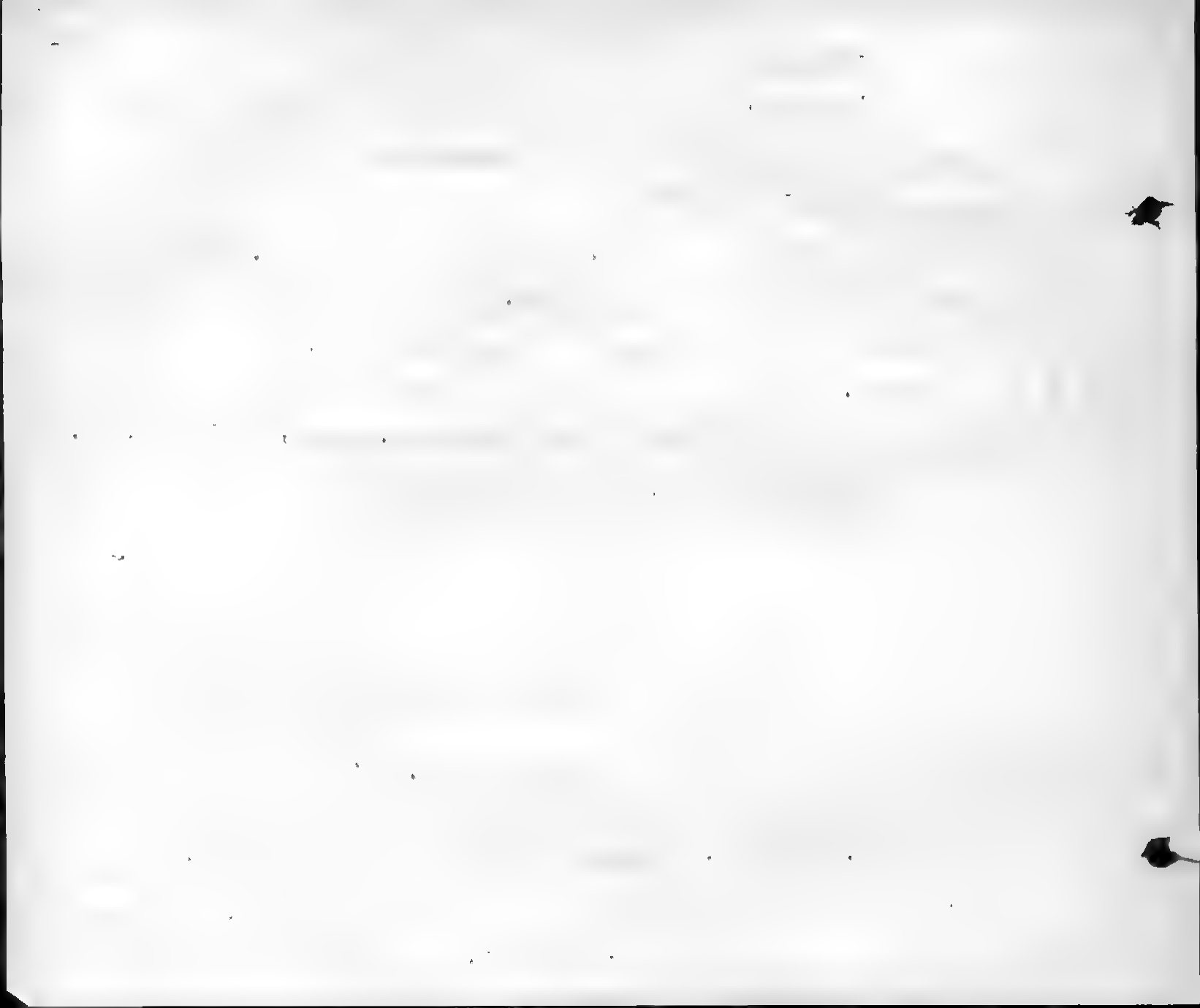
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/58

1
10076
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10047

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b House in the Pines Nursing and Convalescent Home		2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before adm ssion) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS Arbutus Avenue	
3 NAME OF DECEASED (Type or print) First Marie Middle L. Last Spoerer		4 DATE OF DEATH Month Sept. Day 15th Year 19 60	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 21 1876
9 AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis C. Smith		14. MOTHER'S MAIDEN NAME Elisabeth Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs Raymond P. Delano		Address Nottingham, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Longtime Heart Failure DUE TO (b) Secondary arteriosclerosis DUE TO (c) Arteriosclerosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Sept 21 155
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 7-12-1960 to 7-15-1960 , that (I) (we) lost the deceased alive on 7-12-1960 , and that death occurred 11:45 A.M. from the causes and on the date stated above.			
22a SIGNATURE Wilmer K. Gallagher		22b DATE SIGNED 7-15-60	
22c PHYSICIAN'S NAME (Type) Dr. Wilmer K. Gallagher		22d ADDRESS 6209 Frederick Avenue.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 17 1960	
23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City, town, or county) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Ellis Lamoreau		25a REC'D BY REGISTRAR SEP 19 60	
ADDRESS 1003 W. Balto. St.		25b REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10049

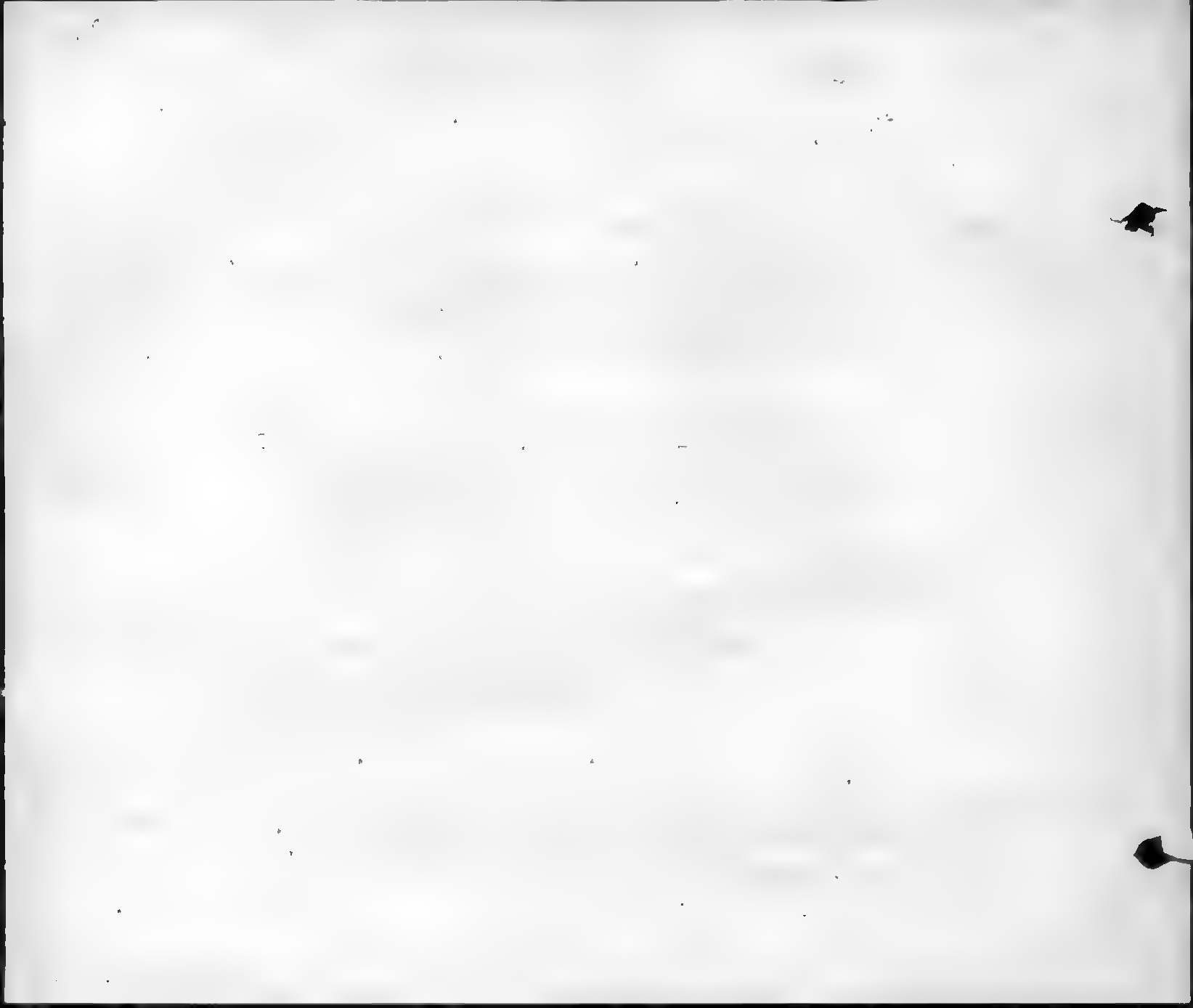
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Maiden Choice Lane		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
3. NAME OF DECEASED (Type or print) First Middle Last Mary L. Stickel		4. DATE OF DEATH Month Day Year Sept. 18, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1886
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Business Form	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Daum		14. MOTHER'S MAIDEN NAME Elizabeth Sellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-6826	
17. INFORMANT Mrs. Charles R. Webber		Address 102 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO (c). PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 52 , to Sept. 18 , 19 60 , that I last saw the deceased alive on Sept. 18 , 19 60 , and that death occurred at 12:57 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Malloy Hill Ave., Baltimore 29, Md. DATE SIGNED 9/20/60			
ACTUAL SIGNATURE Leo J. Geyer M.D.		PHYSICIAN'S NAME (Type) Leo J. Geyer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-21-1960	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong		24a. REC'D BY REGISTRAR SEP 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



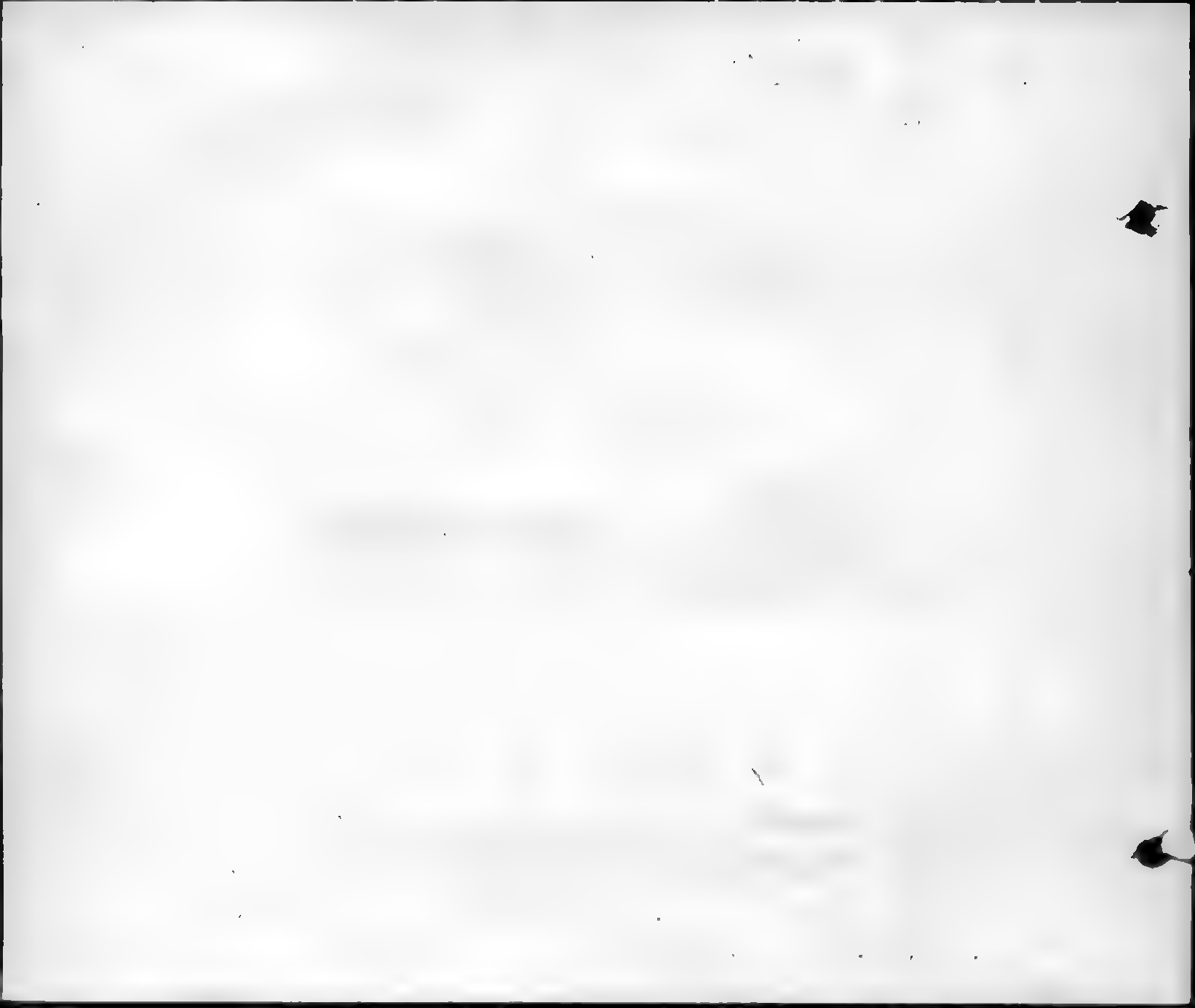
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10050

10078

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY Pri. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 6 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS HYATTSVILLE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN FORNEY STONER		4. DATE OF DEATH Month Day Year SEPT 20 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-23-1886
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN C. STONER		14. MOTHER'S MAIDEN NAME SUSAN E. FORNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 578-050-5575	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4:1 DUE TO Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-27 1957 , to 9-20 1960 , that (I) (we) last saw the deceased alive on 9-19 1960 , and that death occurred at 2:40 P. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 9/20/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-22-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 12k7 St. Paul Street		25a. RECEIVED BY REGISTRAR SEP 22 60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

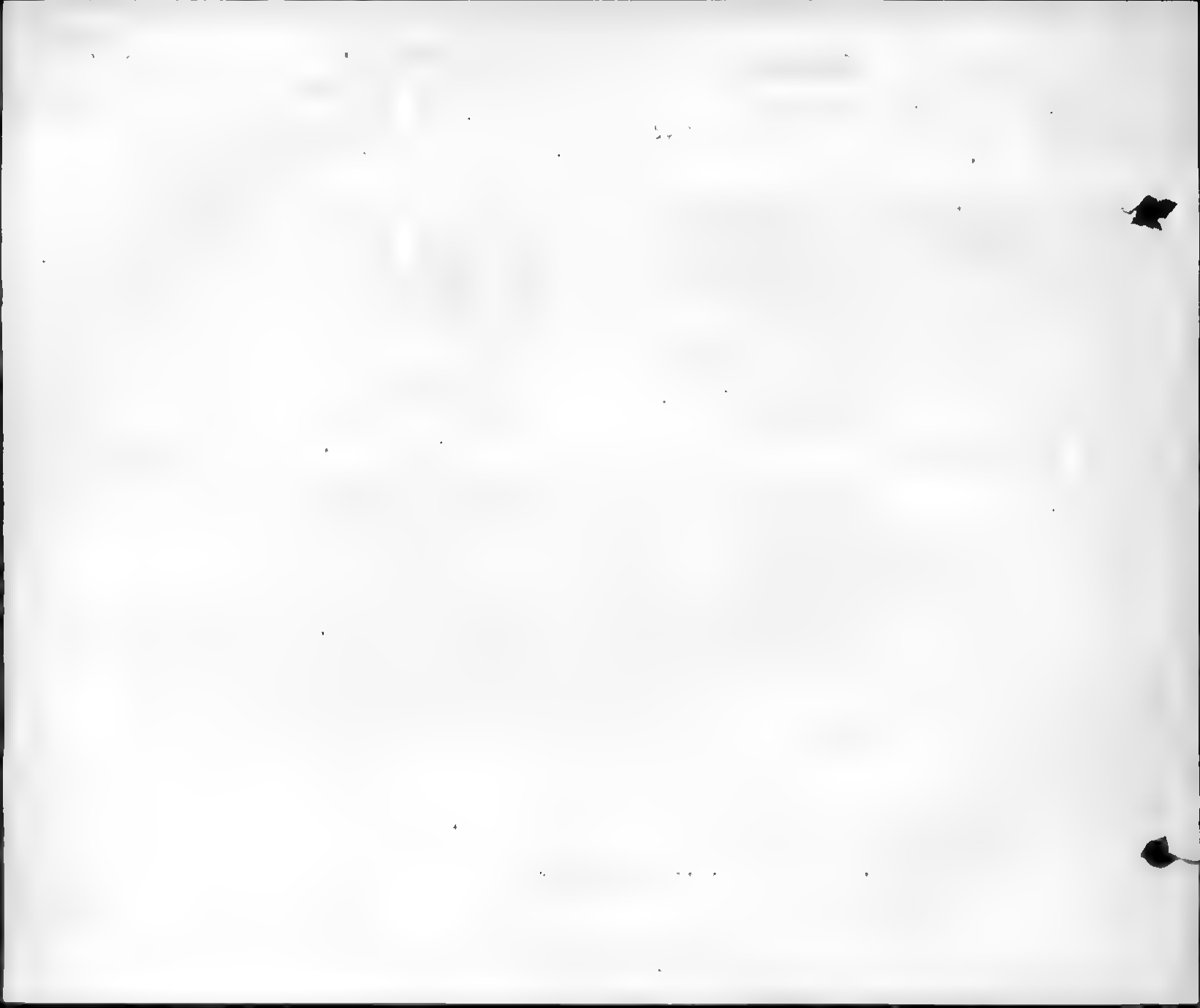
10051
Reg. Dist. No. 32

10079

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saint Pleasant 1712 d. STREET ADDRESS 6810 - Greig St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATE First E Middle STORM Last 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Sept. 26 Month Sept. Day 26 Year 1960 9. AGE (In years last birthday) 75 yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Domestic 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM TUDGE 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME LENA SMITH INFORMANT Hospital Records, Mt. Wilson State Hospital Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pott's disease & mild compression DUE TO and prostatical lesion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pott's disease & mild compression 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9. 1. , 19 60 , to 9. 26. , 19 60 , that I last saw the deceased alive on 9. 26. , 19 60 , and that death occurred at 1 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 9. 26. 1960 ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-28-60 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln 22d. LOCATION (City, town, or county) (State) Bladenburg Md.		23. FUNERAL DIRECTOR'S SIGNATURE 1661 - Wood Hope Rd. SE W.A. Sh. DC 24a. REC'D BY REGISTRAR SEP 27 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

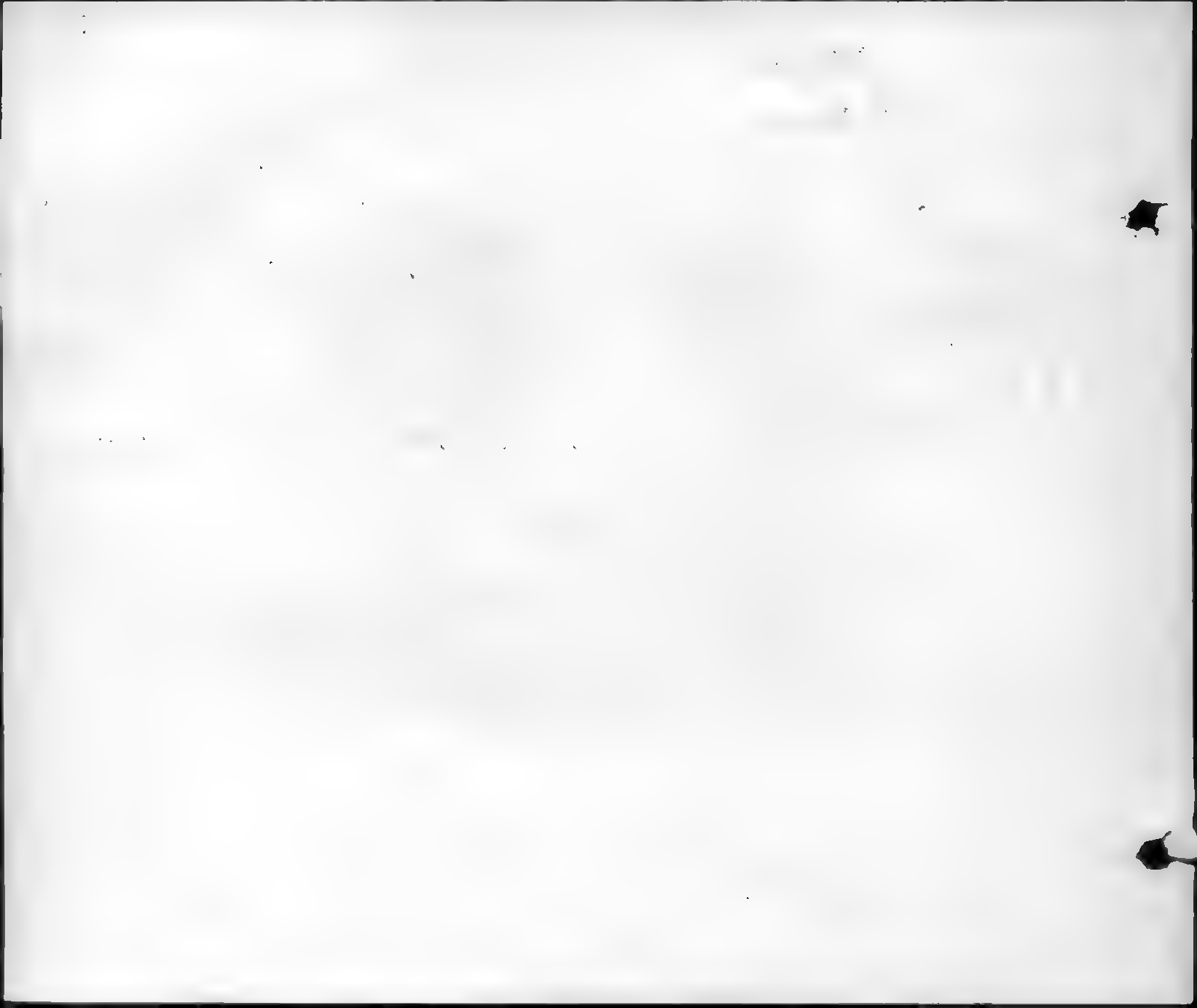


may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
10088
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10052

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harst.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodmoor</i>				c. LENGTH OF STAY IN 1b <i>7 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3439 Hayta Road</i>				e. STREET ADDRESS <i>13439 Hayta Road</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Annette W. Statler</i>				4. DATE OF DEATH Month Day Year <i>Sept. 8/60 19</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4, 1876</i>	9. AGE (In years lost birthday) <i>84</i> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Woods</i>				14. MOTHER'S MAIDEN NAME <i>Rachel Martin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs. Elmer E. Shellkopf</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Hypertensive Artherosclerotic Cardio Vascular W.</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 19 <i>58</i> to <i>Sept 8</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>Sept 7</i> 19 <i>60</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Albert Scagnetti</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <i>Sept 8 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALBERT SCAGNETTI</i>		22d. ADDRESS <i>1724 W Lombard St</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>Sept. 8/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Glenn Creek Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>New Lisbon, Penna.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witke, F. N.</i>		ADDRESS <i>4101 Edmondson Ave</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
				DATE <i>SEP 13 '60</i>			



10081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>BALTO COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Nite Harrington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nite Harrington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6118 Falls Road</u>		d. STREET ADDRESS <u>6118 Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>O</u> Last <u>Streeth</u>		4. DATE OF DEATH <u>26</u> Month <u>7</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 - 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Thomas</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Branch Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Folk Streeth</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>243-10-1269A</u>	
17. INFORMANT <u>Miss Ruth O Streeth</u> Address <u>6118 Falls Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1957</u> to <u>7/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-1-60</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Victor Richards</u> M.D.		ADDRESS (Street, city or town, state) <u>321 - DUNKIRK RD</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles Victor Richards</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 1 - 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town or county) (State) <u>near Towson Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burger Funeral Home</u> ADDRESS <u>3637 Falls Road</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>
		DATE <u>SEP 30 '60</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10082

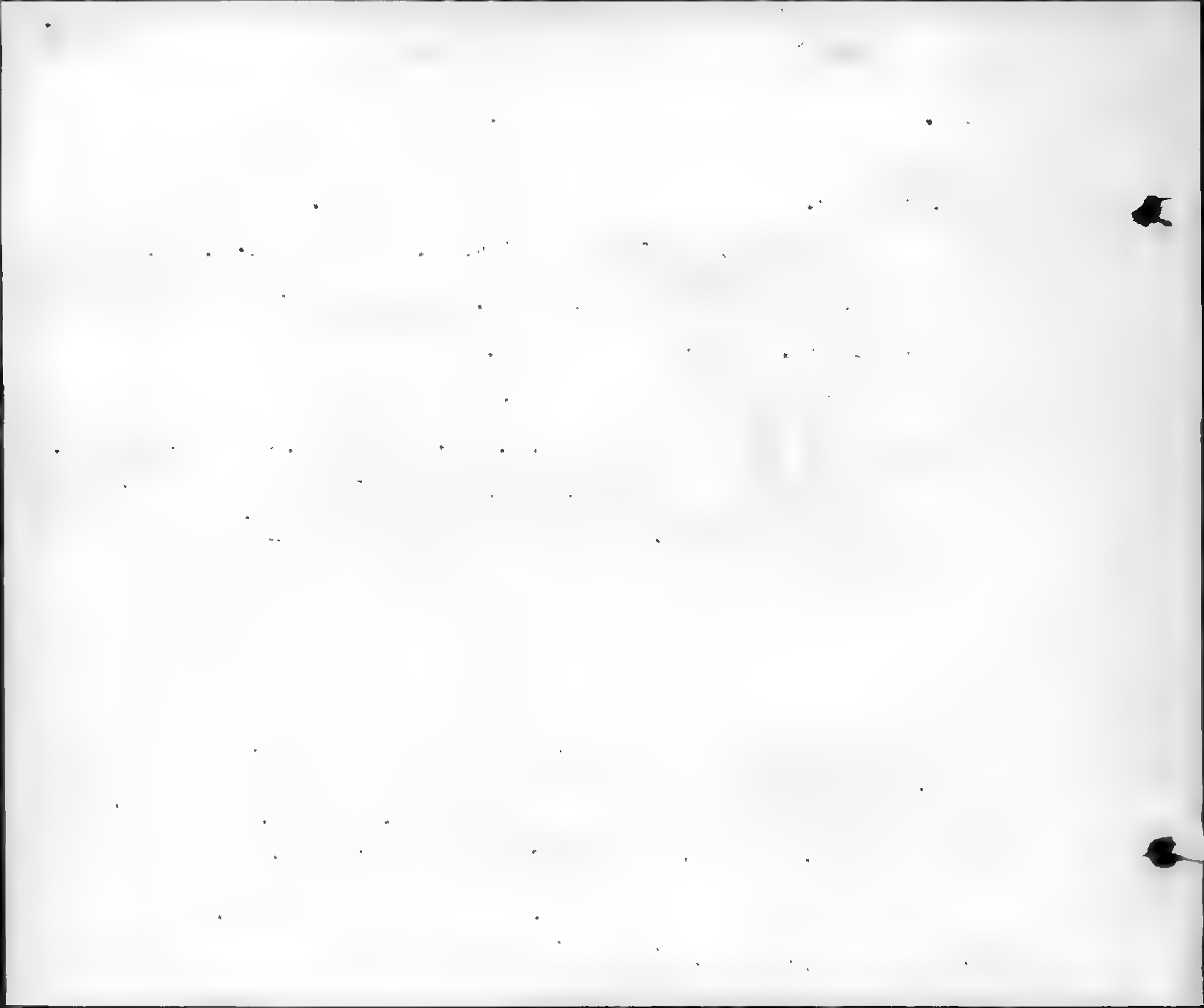
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) 22 Sheraton Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERNARD Middle EDWARD Last SUTER, Sr.				4. DATE OF DEATH Month Sept. Day 3, Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1903	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months 57 Days 57	IF UNDER 24 HRS Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer - self emp.		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Harry Edward Suter				14. MOTHER'S MAIDEN NAME Ida May Devilbiss			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		INFORMANT Address Mr. B. Edward Suter, Jr. - 4414 Glen Arm Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420-1 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 mo. Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o m. p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 17 md	(County)	(State)		
21. I certify that I attended the deceased from July 20, 1960 to Sept 3, 1960 , that I last saw the deceased alive on Aug 25, 1960 , and that death occurred at 4:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Marvin H. Davis, Md. 9/6/60							
ACTUAL SIGNATURE Marvin H. Davis		M.D. Marvin H. Davis, Md., 6512 Liberty Road, Baltimore 7, Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/60	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Talenier & Sons		ADDRESS 17 md		24a. REC'D BY REGISTRAR SEP 7 '60	24b. REGISTRAR'S SIGNATURE William L. Davis		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

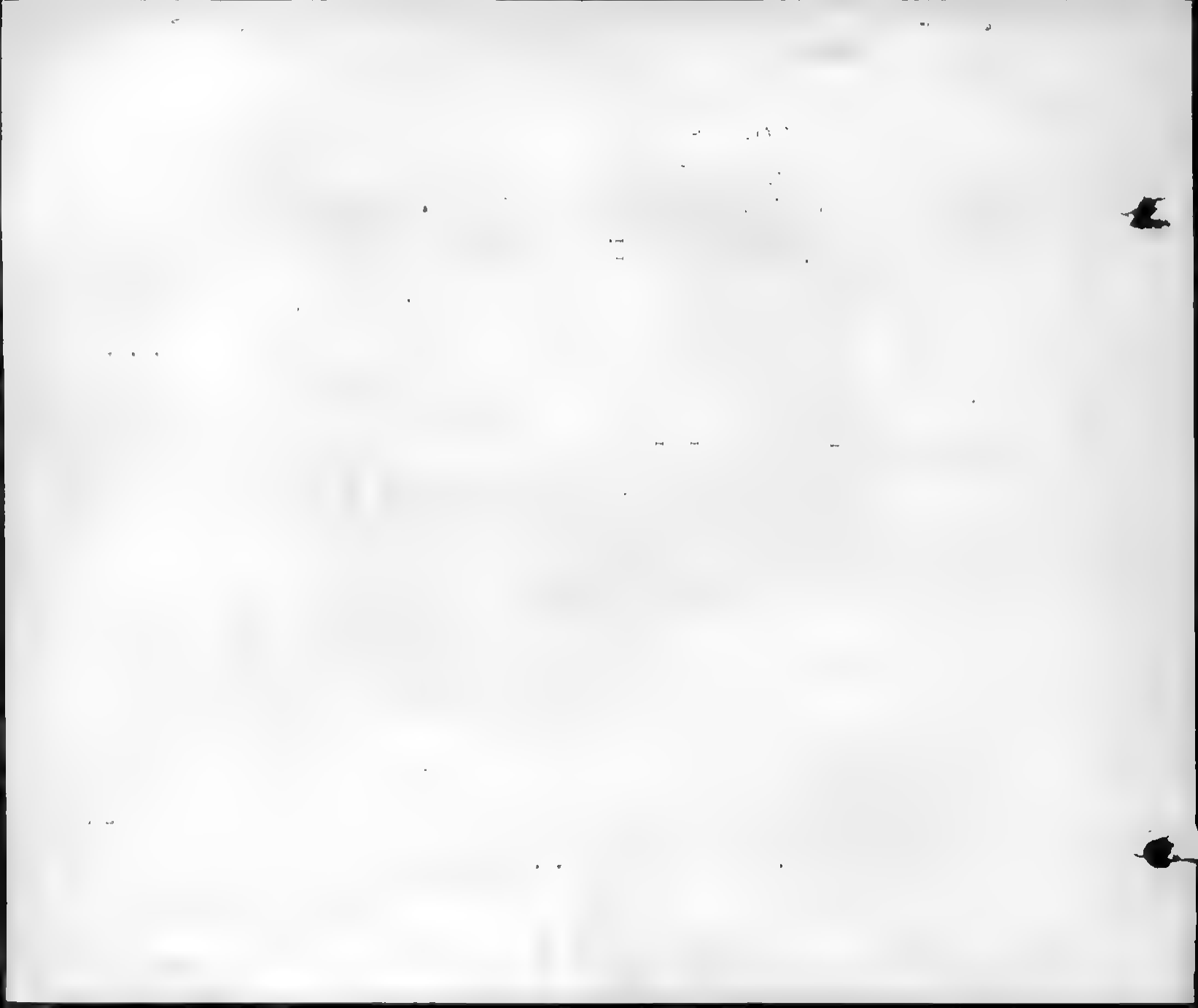
10083

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10055

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 31 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 32 NORTH ELIWOOD AVENUE	
3 NAME OF DECEASED (Type or print) Served as: STEPHEN Middle STROBEL Last SZCZUBLEWSKI		4. DATE OF DEATH Month SEPTEMBER Day 4 Year 19 60	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 12-25-1892
9 AGE (In years last birthday) 67 yrs		10 IF UNDER 1 YEAR Months 4 Days 19 Hours 60 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOX MAKER		10b KIND OF BUSINESS OR INDUSTRY Copper & Brass Co	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW SZCZUBLEWSKI		14. MOTHER'S MAIDEN NAME AGNES KISTOWSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW-1		16 SOCIAL SECURITY NO 213-01-5166	
17 INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that X (this hospital) attended the deceased from August 4, 1960 , to September 4, 1960 , that X (we) last saw the deceased alive on September 4, 1960 , and that death occurred at 6:00 M, from the causes and on the date stated above			
22a SIGNATURE Joseph L. Reeves		22b DATE SIGNED 9-4-60	
22c PHYSICIAN'S NAME (Type) JOSEPH L. REEVES		22d ADDRESS M.D. VAH BALTIMORE MD FT HOWARD DIVISION	
23a BURIAL (Cremation Removal) (Specify) BURIAL		23b DATE THEREOF 9-8-60	
23c NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE John M Weber Funeral Home		25a REC'D BY REGISTRAR SEP 7 '60	
25b REGISTRAR'S SIGNATURE John M Weber		25c REGISTRAR'S SIGNATURE John M Weber	

37



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

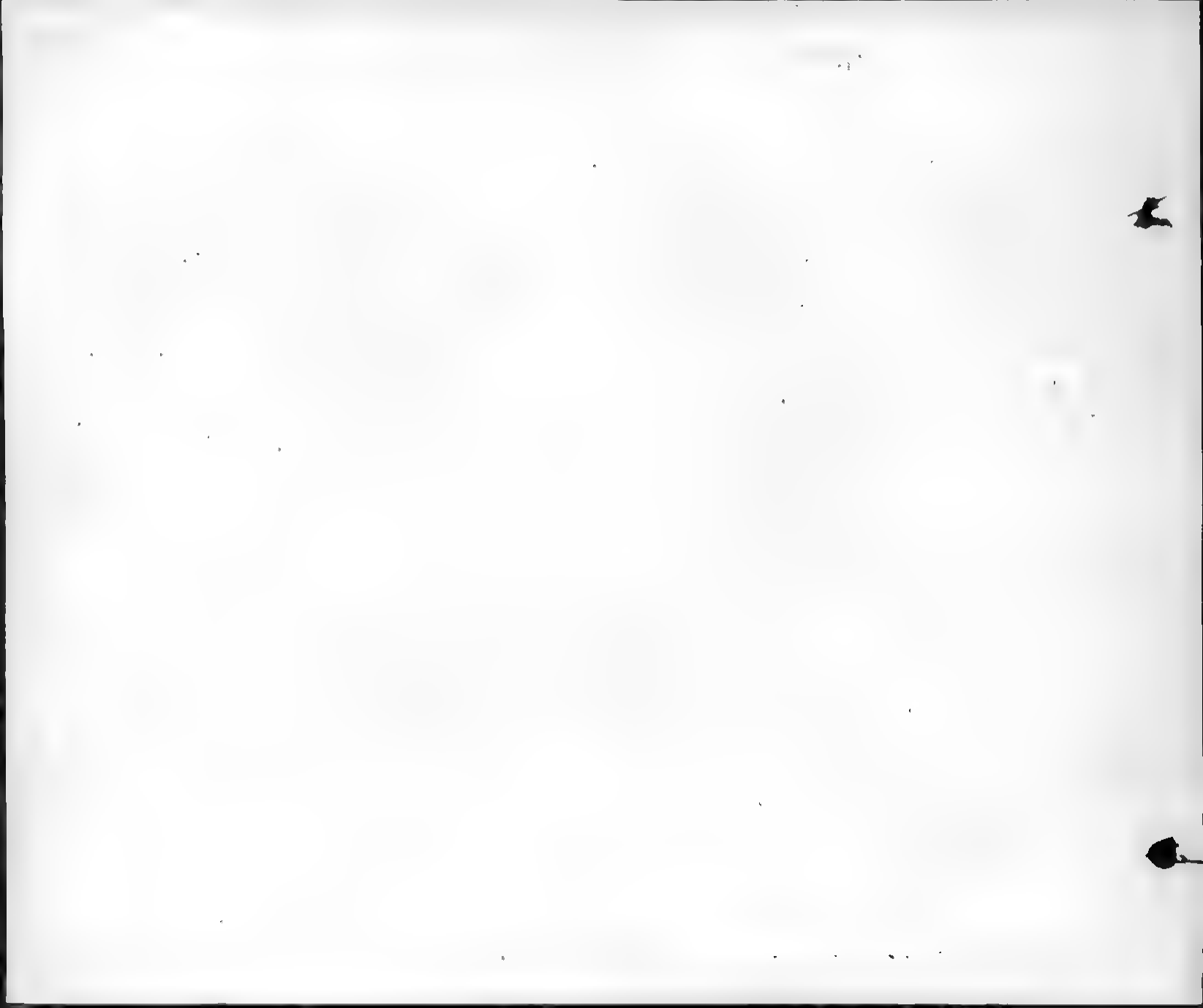
Reg. Dist. No.

10056

10084

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>61 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>418 S. Rolling Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel Louise Taylor</u>		4. DATE OF DEATH Month Day Year <u>Sept. 12, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/1891</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>None</u> <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry J. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Mrs. Nellie Taylor</u>		Address: <u>Catonsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>31 - Cerebral Hemorrhage</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renome. 3rd Arterio Sclerotic</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-11</u> , 19 <u>60</u> , to <u>9-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-12</u> , 19 <u>60</u> , and that death occurred at <u>4 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Catonsville</u> DATE SIGNED <u>9-13</u>			
ACTUAL SIGNATURE <u>James H. Howell</u> M.D.		PHYSICIAN'S NAME (Type) <u>Catonsville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/15/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '60</u>	
ADDRESS <u>Catonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



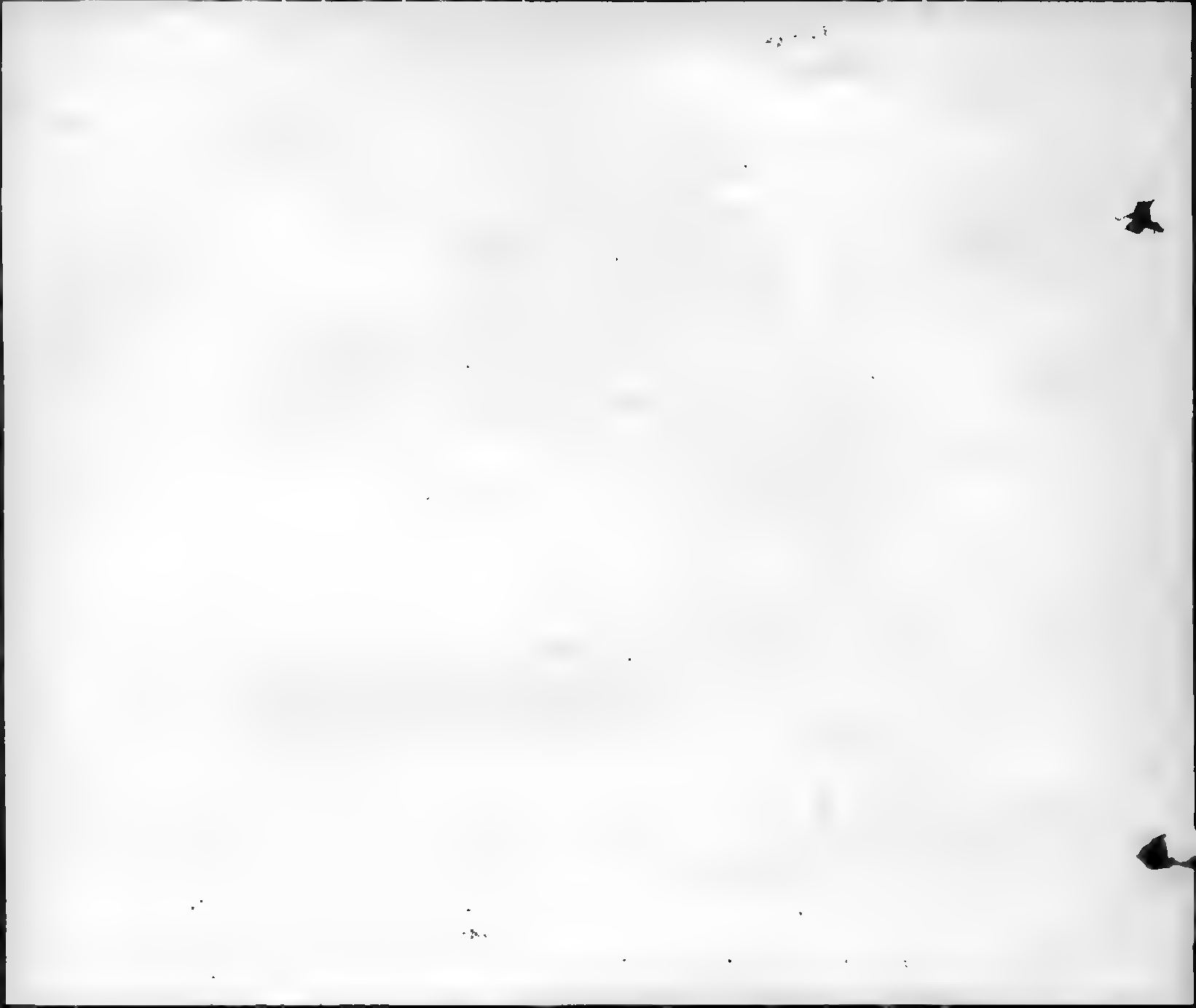
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10057

10085

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>4yr 1mo 1day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rockwood State Training School</u>				d. STREET ADDRESS <u>2814 Ganley Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>Testerman</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>14</u> - Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-51</u>		9. AGE (in years last birthday) <u>8</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Allen Claude Testerman</u>				14. MOTHER'S MAIDEN NAME <u>Alice Mae Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Allen C Testerman 2814 Ganley Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> DUE TO (b) <u>Mental Retardation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>since birth</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-3-1956</u> to <u>9-14-1960</u> that (I) (we) last saw the deceased alive on <u>9-14-1960</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. R. Law</u>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-14-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. R. Law M.D.</u>		22d. ADDRESS <u>Rockwood State Training School, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 19, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto Natl</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u> ADDRESS <u>1217 St. Paul St.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

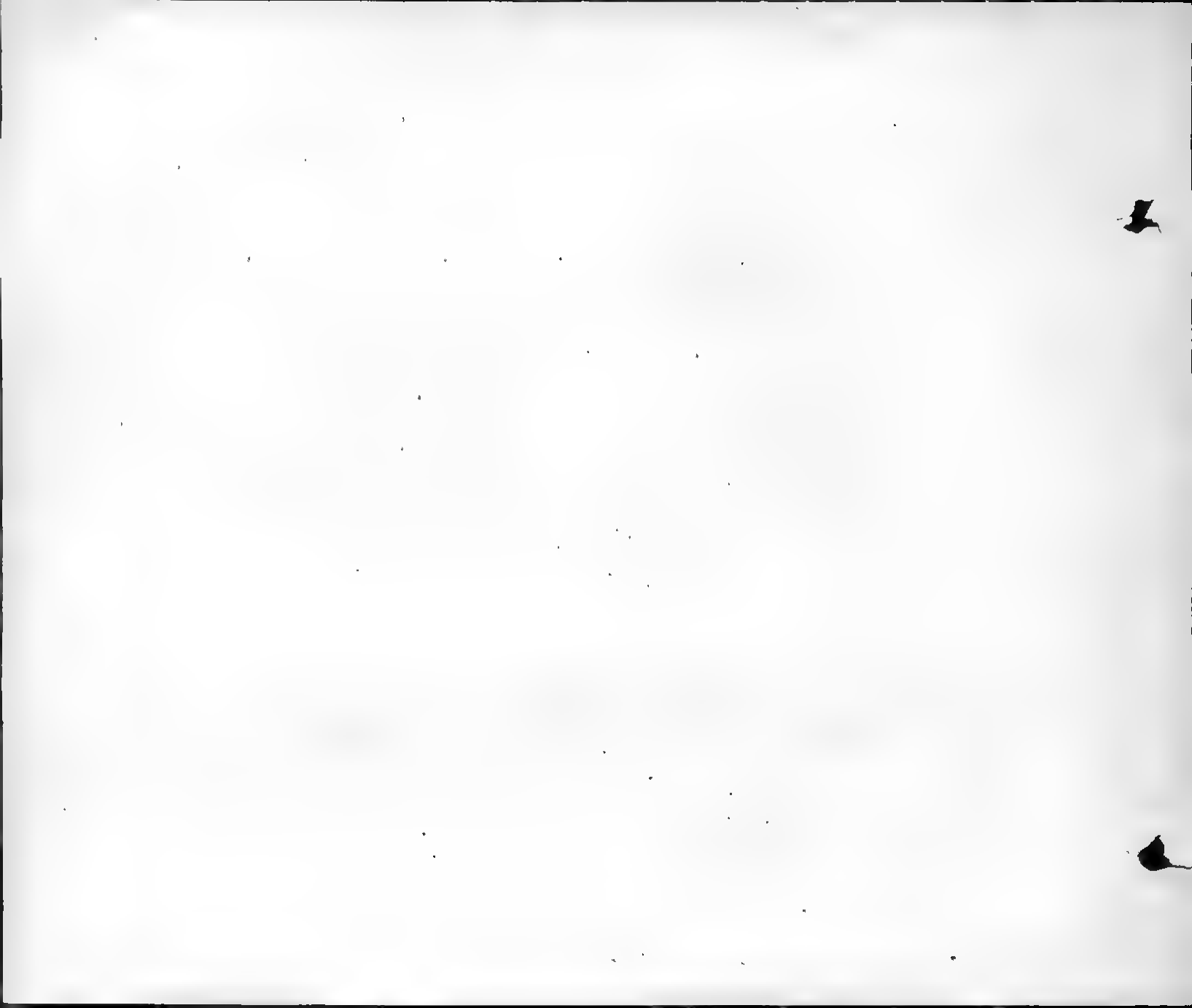
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on 1 completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

1

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Md.</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nelson Rd., Pikesville 8, Md.</u>				d. STREET ADDRESS <u>Nelson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
<u>John James Thomas Sr.</u>				<u>Sept. 11,</u>		<u>1960</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs	
<u>Male</u>	<u>White</u>			<u>Aug 24, 1906</u>		<u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Fluider</u>		<u>J.W. Marchant</u>		<u>Philadelphia, Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Thomas</u>				<u>Margaret McGeath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
<u>None</u>				<u>Mrs. Mary E. Thomas, Nelson Rd., Pikesville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 4, 1960</u> , to <u>SEPT. 11, 1960</u> that I last saw the deceased alive on <u>SEPT. 11, 1960</u> and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Samuel P. Scalia</u> M.D. <u>1331 Reisterstown Road</u> <u>9/13/60</u> <u>Pikesville 8, Md.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 14, 1960</u>		<u>Druid Ridge Cemetery</u>		<u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Frank H. Newell</u>				<u>SEP 15 '60</u>		<u>Arthur S. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

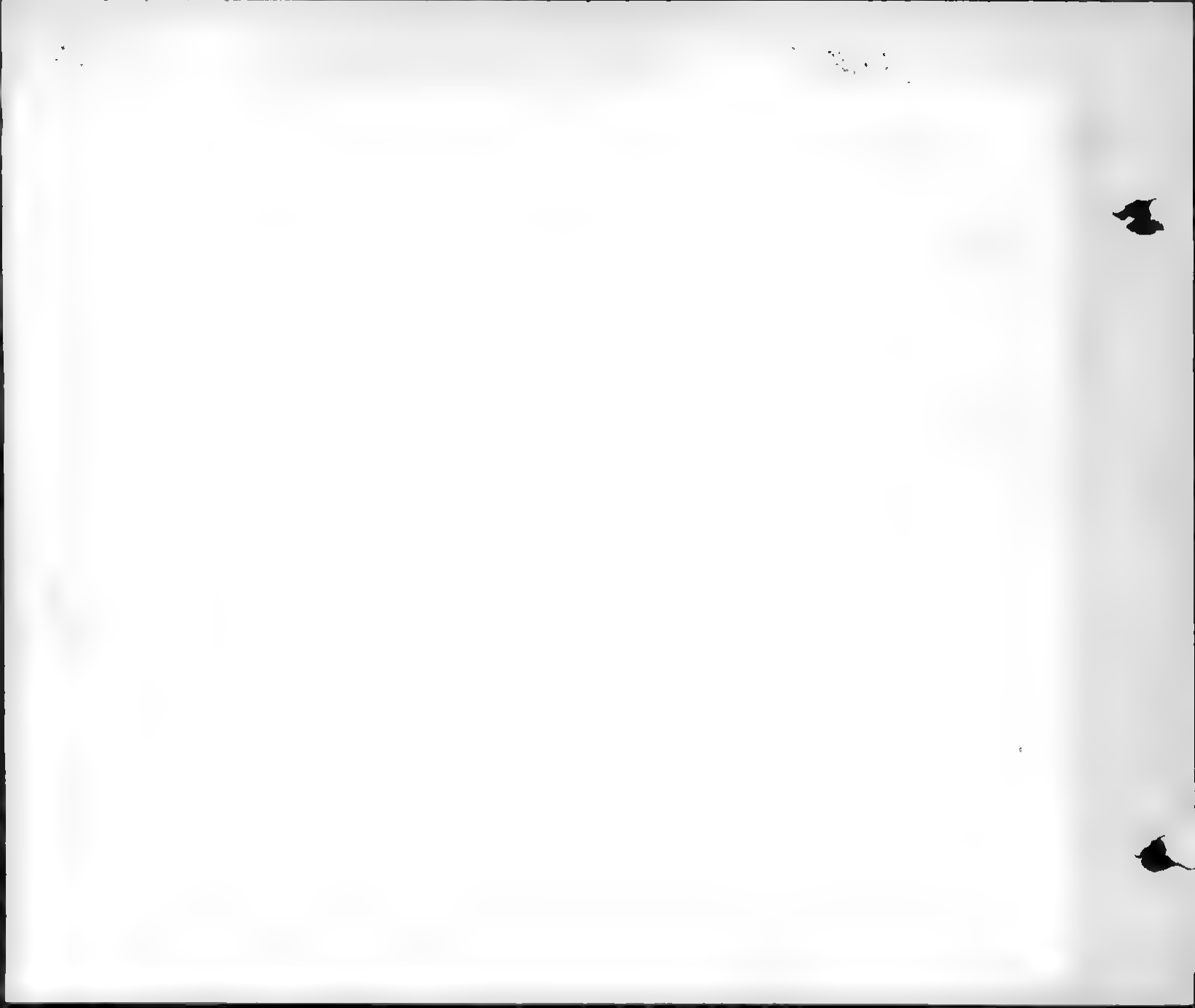
10087

10059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) <i>ARTHUR F. X. J. Thorpe Jr</i>		2. DATE OF DEATH <i>Sept. 5, 1960</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> FULL NAME OF HOSPITAL OR INSTITUTION <i>1253 Dartmouth Rd</i> <i>Baltimore, MD</i>		4. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore - 12</i> (If outside city limits, write RJRAL and give township) D. STREET ADDRESS (If rural, give location) <i>1253 Dartmouth Rd</i>							
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb 29, 1948</i>	9. AGE (in years last birthday) <i>12</i>	10. A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>CHS</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>CHS</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ARTHUR F. J. Thorpe Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Hilda Lyons</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>mother.</i>	ADDRESS

18. CAUSE OF DEATH	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Probable intra aortic aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH		
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>metastatic malignancy (undifferentiated endometrial carcinoma)</i>				
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT				
	19A. DATE OF OPERATION <i>January 1960</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>metastatic malignancy</i>		
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 5, 1960</i> to <i>Sept. 5, 1960</i> that (I) (we) last saw the deceased alive on <i>Sept. 3, 1960</i> and that in (my) (our) opinion death occurred at <i>11:50 A.M.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Quinn Hagg</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23B. ADDRESS <i>4726 Old Court Rd</i>		23C. DATE SIGNED <i>Sept 5, 1960</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-7-60</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Memorial</i>	
24D. LOCATION (City, town, or county) <i>Baltimore County, Md</i>		24E. NAME OF REGISTRAR <i>H. Cook</i>		25. FUNERAL DIRECTOR <i>H. Cook-Towson, Inc., 1050 York Road</i>	



1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1008 J Street				d. STREET ADDRESS 1008 J Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Caroline (Tilghman) Tillman				4. DATE OF DEATH Month Day Year September 11 1960					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1888			
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Wadesboro, N. C.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME George Lomax				14. MOTHER'S MAIDEN NAME Elizabeth Benton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Eli Tillman - 1008 J St., Sparrows Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Left hemiplegia DUE TO (c) Arterio-sclerosis & hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 25/60 to Sept 11th 60 that I last saw the deceased alive on September 11, 1960 , and that death occurred at 12:30 PM from the causes and on the date stated above ADDRESS (Street, city or town, state) 107 N. Main St. Balto 22 Md									
ACTUAL SIGNATURE J. H. Thomas		M.D. 107 N. Main St. Balto 22 Md							
PHYSICIAN'S NAME (Type) J. H. Thomas									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 202 Madison Ave.				24a. REC'D BY REGISTRAR DATE SEP 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

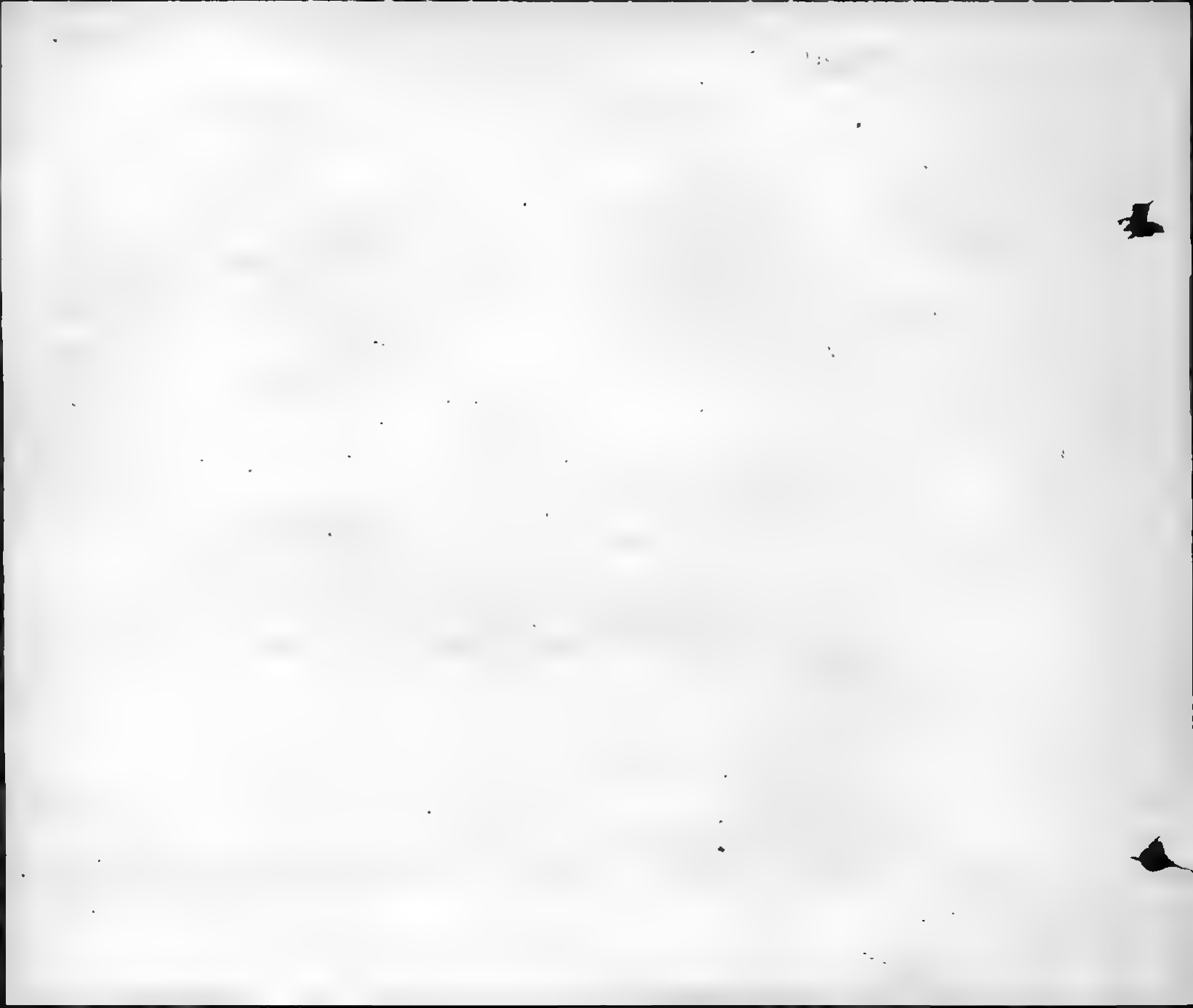
VS A15 (4)
15M 10/57



10061

10089

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Andy's Home</u>				d. STREET ADDRESS <u>1 Hullview Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna E. Tracey</u>				4. DATE OF DEATH Month Day Year <u>Sept 3 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/21/90</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jacob Haemel</u>				14. MOTHER'S MAIDEN NAME <u>Catherine E. Rosbach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Walter K. Tracey</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>myocardial insufficiency</u> DUE TO (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>18 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertrophic arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 12 1959</u> to <u>Sept 3 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 3 1960</u> and that death occurred at <u>9:28 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>George A. Knipp</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 3 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>George A. Knipp M.D.</u>				22d. ADDRESS <u>4116 Edmondson Ave Balto 29 Md</u>			
23a. BURIAL CREMATION, (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/6/60</u>		<u>Woodlawn</u>		<u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. [Signature]</u>				ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

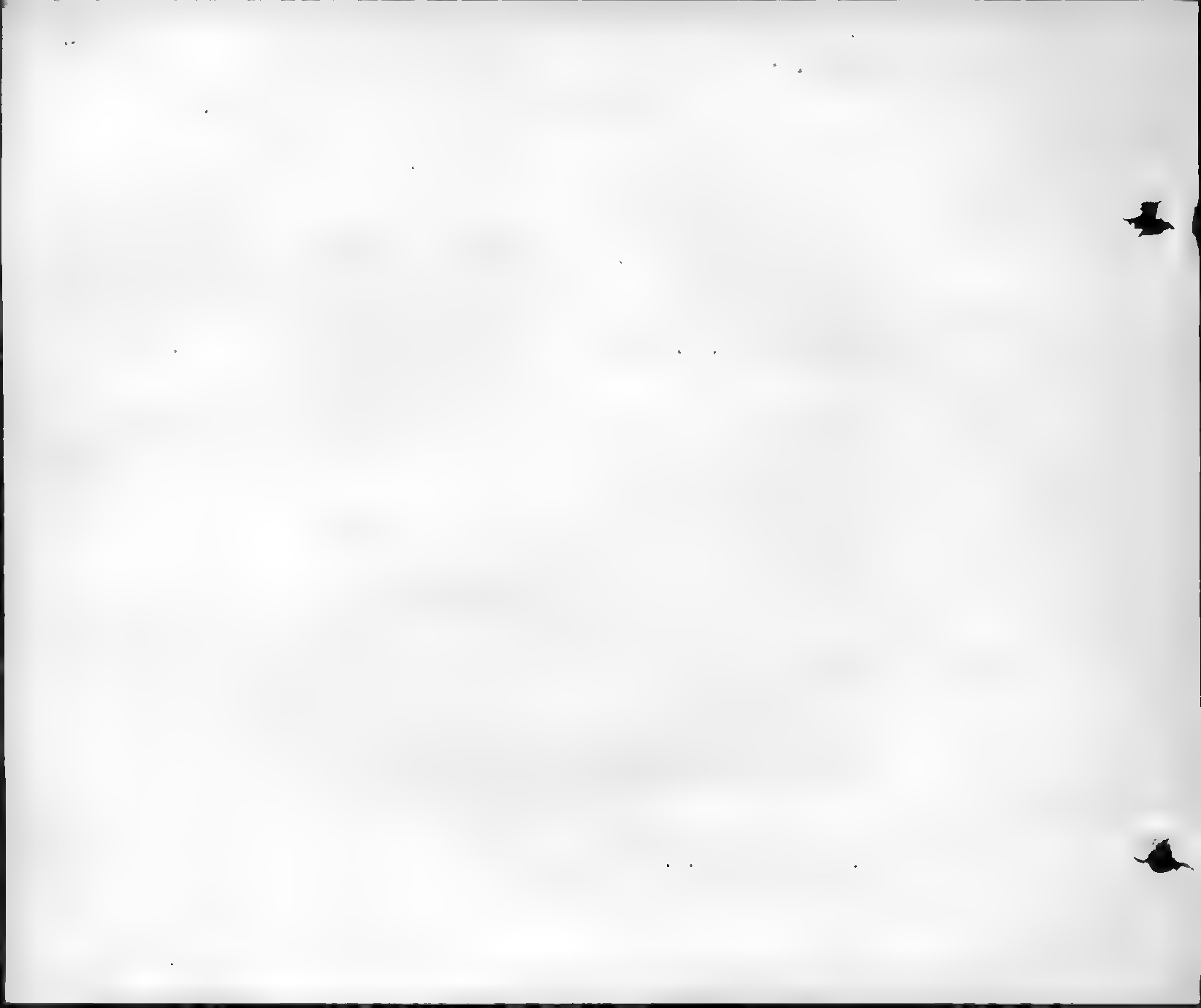


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10062

10090

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 22 New Street			
3. NAME OF DECEASED (Type or print) First CHARLES Middle D. Last TRUMP				4. DATE OF DEATH Month September Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1939	
9. AGE (in years last birthday) 21 yrs		10. IF UNDER 1 YEAR Months 21 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier-Airman				10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force		11. BIRTHPLACE (State or foreign country) Manchester, Maryland	
13. FATHER'S NAME Charles R.				14. MOTHER'S MAIDEN NAME Ethel Masemore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 3/6/57;3/30/59 214-36-9191		17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE LYMPHOCYTIC LEUKEMIA DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 20 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12, 1960 to September 28, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 28, 1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i> 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22b. ADDRESS VAH, BALTO. 18, MD FORT HOWARD MAXX DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-1-1960		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____ Manchester, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edw. C. Tipton, Hampstead, Maryland				25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE <i>John L. Hume</i>	



10091

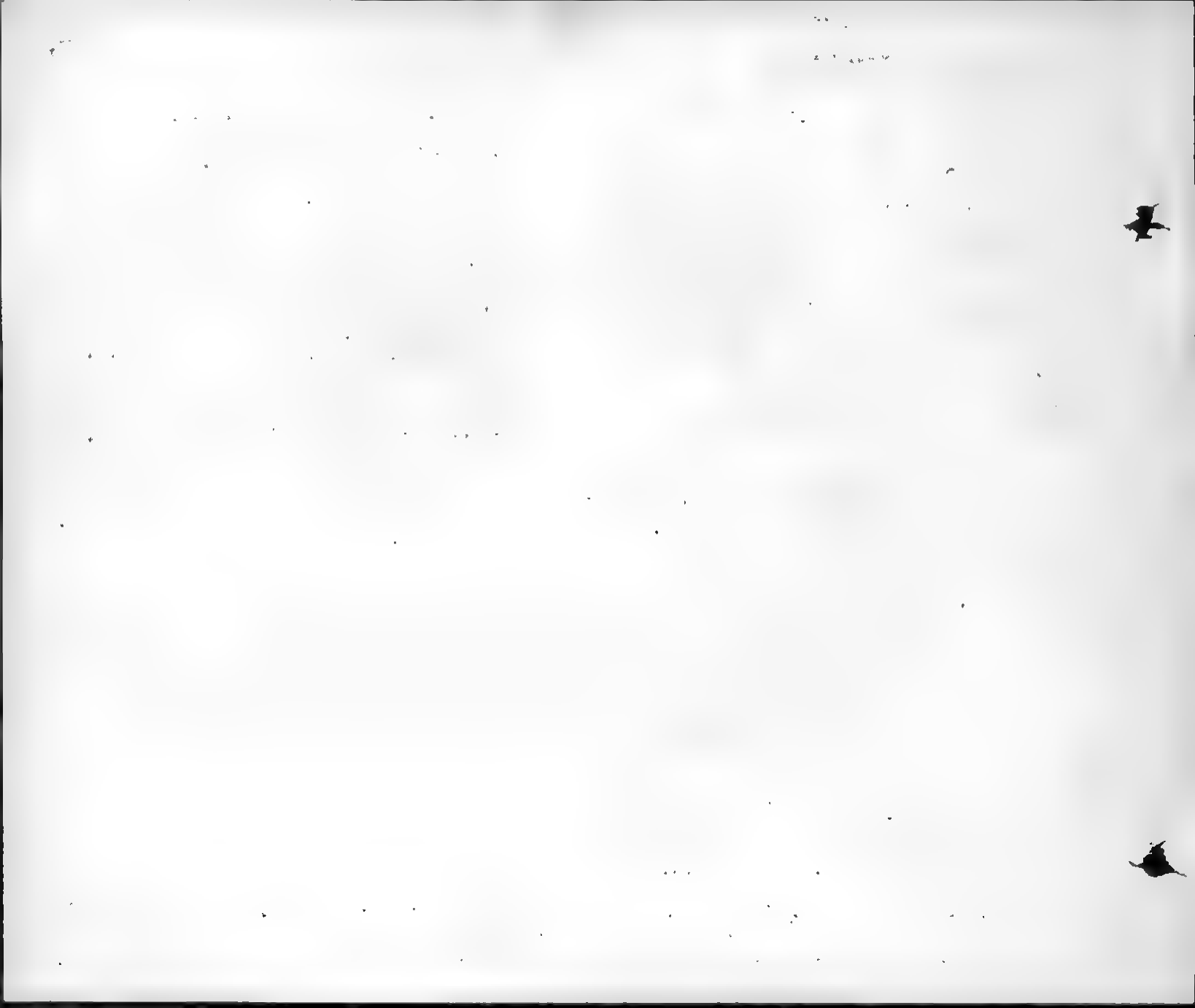
CERTIFICATE OF DEATH

Reg. Dist. No. 10064

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto., City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Cordell Last Tyson		4. DATE OF DEATH Month 9 Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1960
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 16 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Tyson		14. MOTHER'S MAIDEN NAME Gloria Inez Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
INFORMANT Rosewood Records		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smothering 752 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hydrocephalus non communicans (c) ing		INTERVAL BETWEEN ONSET AND DEATH 14 days Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/22 - 1960 to 9/12 - 1960 that I last saw the deceased alive on 9/12/1960 , and that death occurred at 10:22 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills, Md DATE SIGNED 9/14/60	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/60	
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or county) (State) Murichick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lynch ADDRESS 2463 Grind Hill Ave		24a. REC'D BY REGISTRAR SEP 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

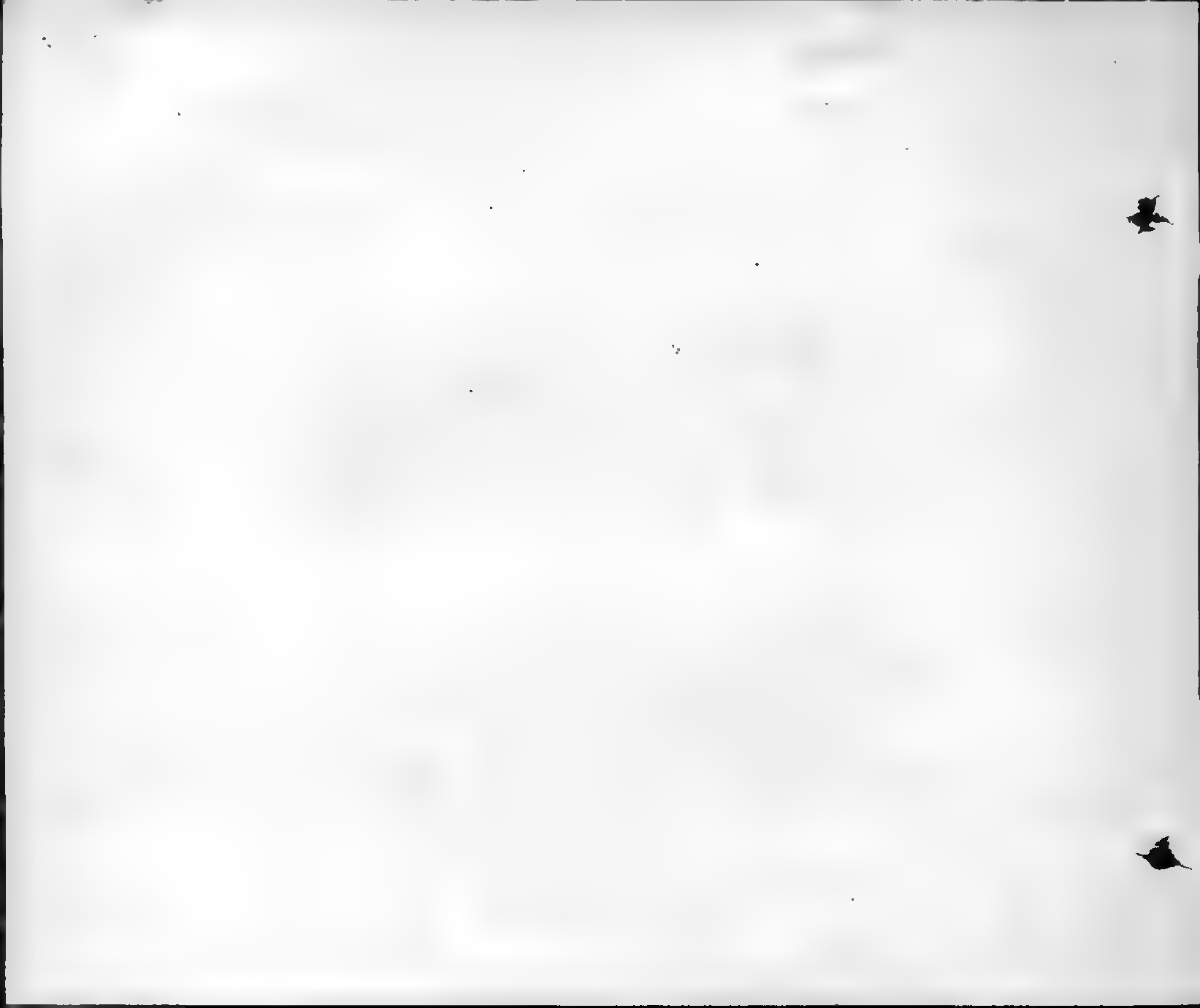
10092

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10065

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> 62	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2120 Frederick Rd.</u>		d. STREET ADDRESS <u>2120 Frederick Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>J. FREDERICK VOGT</u>		4. DATE OF DEATH Month Day Year <u>Sept 10 1960</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1893</u>
9 AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker Am. Can.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Vogt</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Weiland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>212 09586</u>	
17. INFORMANT <u>John E. Vogt</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis (General)</u> (c) <u>18 day</u> 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> 19 <u>60</u> to <u>9-10</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9-10</u> 19 <u>60</u> and that death occurred at <u>10:45</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>James Entwistle</u> M.D.		22b. DATE SIGNED <u>9-12</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Catonville</u>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/13/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Cato. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. + Son</u>		25a. REC'D BY REGISTRAR <u>28</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur P. H...</u>		DATE <u>SEP 14 '60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

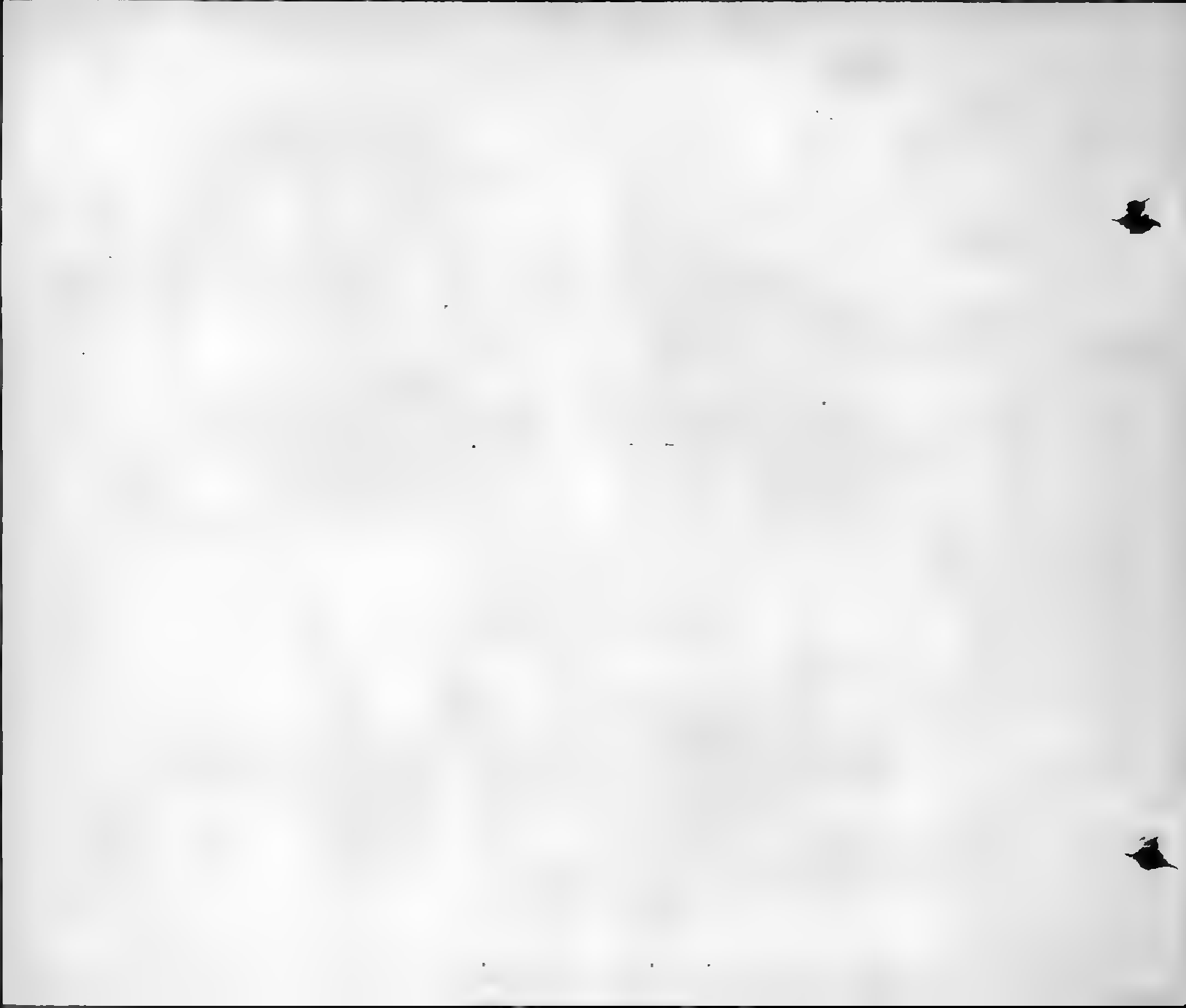
10066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 262 Patapsco Avenue				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 262 Patapsco Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First WALTER Middle LEE Last WAMSLEY				4. DATE OF DEATH Month September Day 6th , Year 1960															
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Retail Paint		11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William L. Wamsley						14. MOTHER'S MAIDEN NAME Anne Martin													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 233-18-8211		17. INFORMANT Address May P. Wamsley same as #2													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-sclerotic heart dis. 720.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Art. Sclerosis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 10 yrs 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Jack C. Collins</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 9/7/60							
EXAMINER'S NAME (Type) Jack C. Collins				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 9/9/60		22c. NAME OF CEMETERY OR CREMATORY Boring Cemetery		22d. LOCATION (City, town, or county) Davidson Run, West Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.														24a. REC'D BY REGISTRAR SEP 8 '60		24b. REGISTRAR'S SIGNATURE <i>Clara S. Kline</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

10067

10093

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle WASHBURN Last WASHBURN		4. DATE OF DEATH Month Sept. Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1871
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Theodore Hessinger		14. MOTHER'S MAIDEN NAME Caroline Engelkirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO INFORMANT	
17. ADDRESS Sarasota, Fla.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to present , that I last saw the deceased alive on 9/13 , 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest C Brown		ADDRESS (Street, city or town, state) 1101 N. Calvert St	
PHYSICIAN'S NAME (Type) Ernest C Brown		DATE SIGNED 9/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Chabner & Sons - Balto		24a. REC'D BY REGISTRAR SEP 19 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10094

10068

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17)	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 708 North Bruce Street	

3. NAME OF DECEASED (Type or print) First SAMUEL Middle E. Last WATERS		4. DATE OF DEATH Month September Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	IF UNDER 24 HRS Months 65 Days 65 Hours 65 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	---	---

13. FATHER'S NAME Jim Waters	14. MOTHER'S MAIDEN NAME Annie Hawkins
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 213-10-3037	17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division
--	---	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTER. AL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS		1 WEEK
DUE TO (b) GLOMERULONEPHRITIS		UNKNOWN
DUE TO (c) ANASARCA AND NEPHROTIC SYNDROME		1 MONTH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that **he** (this hospital) attended the deceased from **Sept. 20 11:45** to **Sept. 28 1960**, that **he** (we) last saw the deceased alive on **Sept. 28 1960**, and that death occurred at **P. M.** from the causes and on the date stated above.

22a. SIGNATURE C. M. SNYDER, M.D.	22b. DATE SIGNED 9/29/60
22c. PHYSICIAN'S NAME (Type) C. M. SNYDER, M.D.	22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION

23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-3-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore Maryland
---	-------------------------------------	---	---

24. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick	ADDRESS 1412 E. Preston St., Balto. Md.	25a. REC'D BY REGISTRAR OCT 4 '60	25b. REGISTRAR'S SIGNATURE Charles P. House
--	---	---	---

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No.

10069

10095

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7222 Hilltop Avenue</u>		d. STREET ADDRESS <u>1 7222 Hilltop Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>AUGUSTA</u> Middle <u>WEAVER</u> Last		4. DATE OF DEATH <u>SEPT</u> Month <u>20</u> Day <u>1960</u> Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles M. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Rose M. Preston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Mildred M. Appel</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 years</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 1</u> , 19 <u>60</u> , to <u>SEPT 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>SEPT 20</u> , 19 <u>60</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>	
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>		DATE SIGNED <u>9/20/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '60</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Carl G. K...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10096

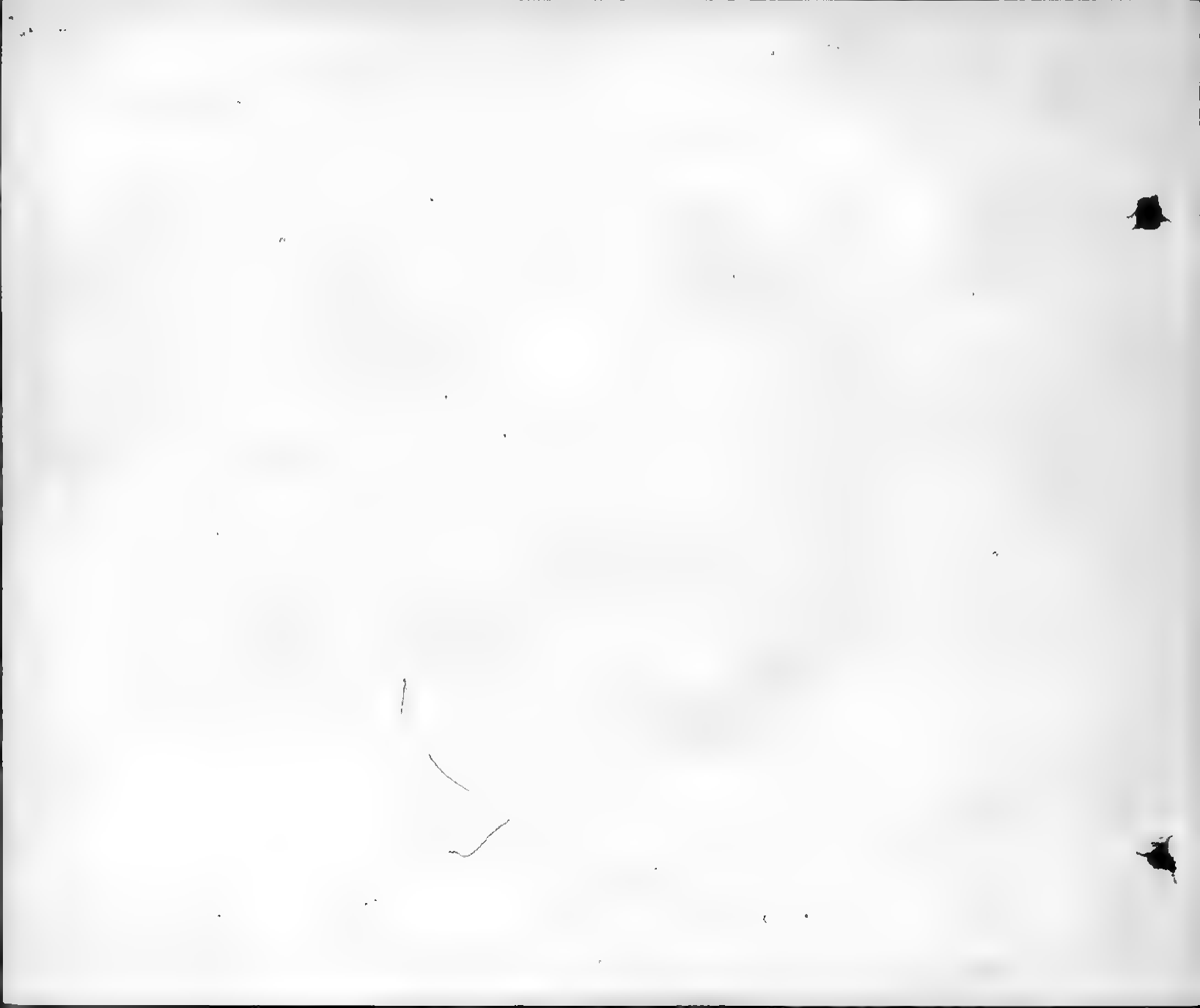
CERTIFICATE OF DEATH

Reg. Dist. No.

10070

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rosevale		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hosp. give street address) OR INSTITUTION 7604 Philadelphia Rd.		e. STREET ADDRESS 7604 Philadelphia Road	
3. NAME OF DECEASED (Type or print) First Wesley Middle LYNN Last Weisman		4. DATE OF DEATH Month Sept. Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1882
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min 78	11. IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Levee Bros.	
11. BIRTHPLACE (State or foreign country) East Brady, Penna.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Charles Weisman		14. MOTHER'S MAIDEN NAME Emily Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-14-4116	
17. INFORMANT Martha H. Weisman		Address 7604 Philadelphia Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6 Mos. (b) 6 Mos. (c) 6 Mos.			INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1960 to SEPT 20, 1960 , that I last saw the deceased alive on SEPT 20, 1960 , and that death occurred at 11:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Emmett P. Davis M.D.		ADDRESS (Street, city or town, state) BALTIMORE MD	
PHYSICIAN'S NAME (Type) EMMETT P DAVIS		DATE SIGNED SEP 20 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY West End Cemetery		22d. LOCATION (City, town, or county) (State) Wytheville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE A. L. Barnett		ADDRESS Wytheville, Virginia	
24a. REC'D BY REGISTRAR SEP 26 1960		24b. REGISTRAR'S SIGNATURE W. L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

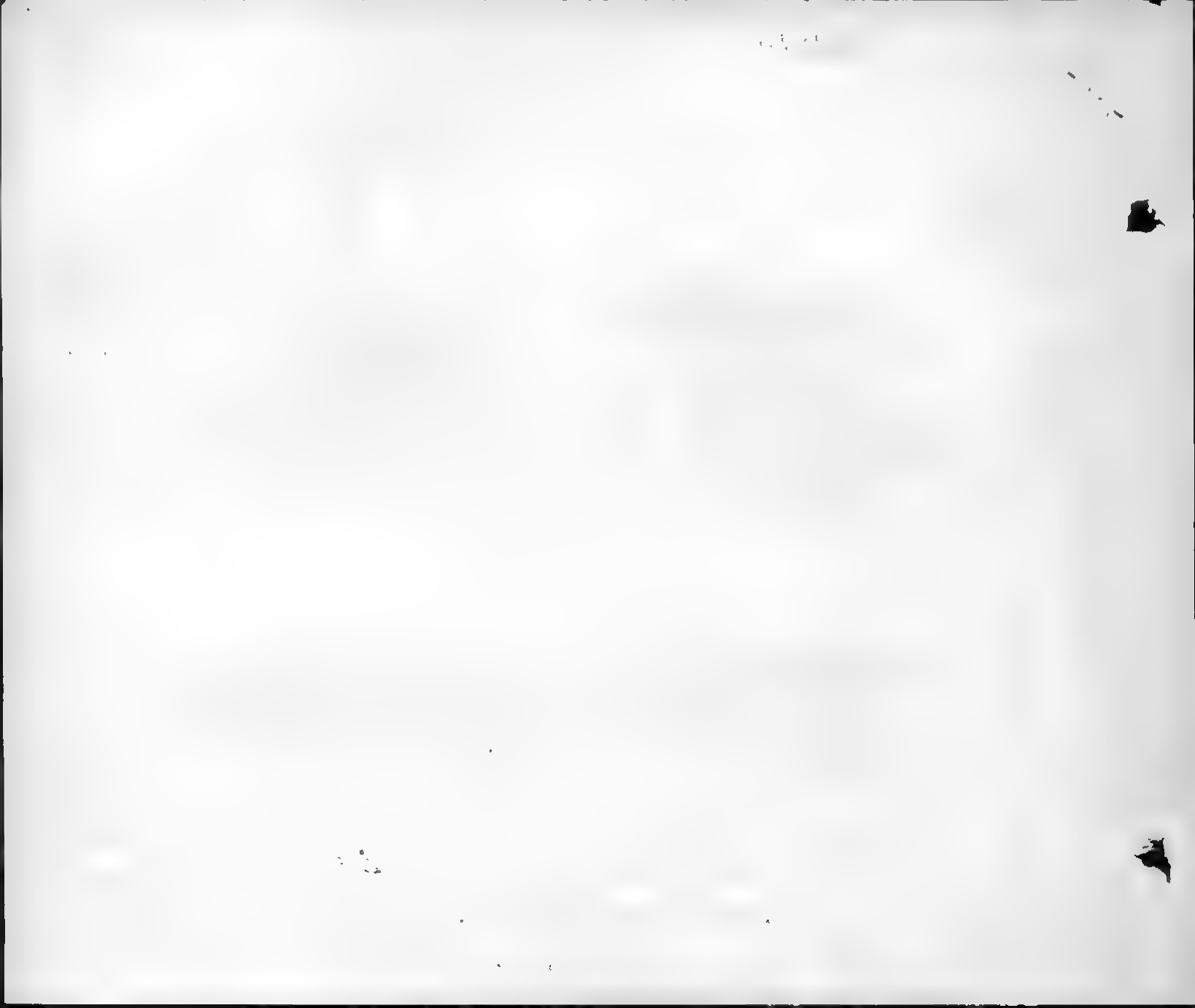
VR A15 (4)
15M 9/59

10097
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10071

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		e. STREET ADDRESS <u>Formerly of 406 Normandy</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond</u> First <u>Wells</u> Middle <u>Wells</u> Last		4. DATE OF DEATH <u>Sept. 7/60</u> 19 <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1888</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.S. Gork</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. Wells</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Raymond Wells, 5436 Monthall Ave</u>	
17. INFORMANT <u>Zone 7</u>		Address <u>Zone 7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular d.</u> (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchial asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1957</u> to <u>Sept 7, 1960</u> that (I) (we) lost the deceased alive on <u>Sept 7, 1960</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>James E. Rowe</u> M.D.		22b. DATE SIGNED <u>9/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u>		22d. ADDRESS <u>1011 Frederick road Cat 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 10/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Ch.</u>		23d. LOCATION (City, town, or county) (State) <u>Worrollawn 7. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke & N. 4101 E. Edmondson Ave</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>W. L. S. Kline</u>	





10099

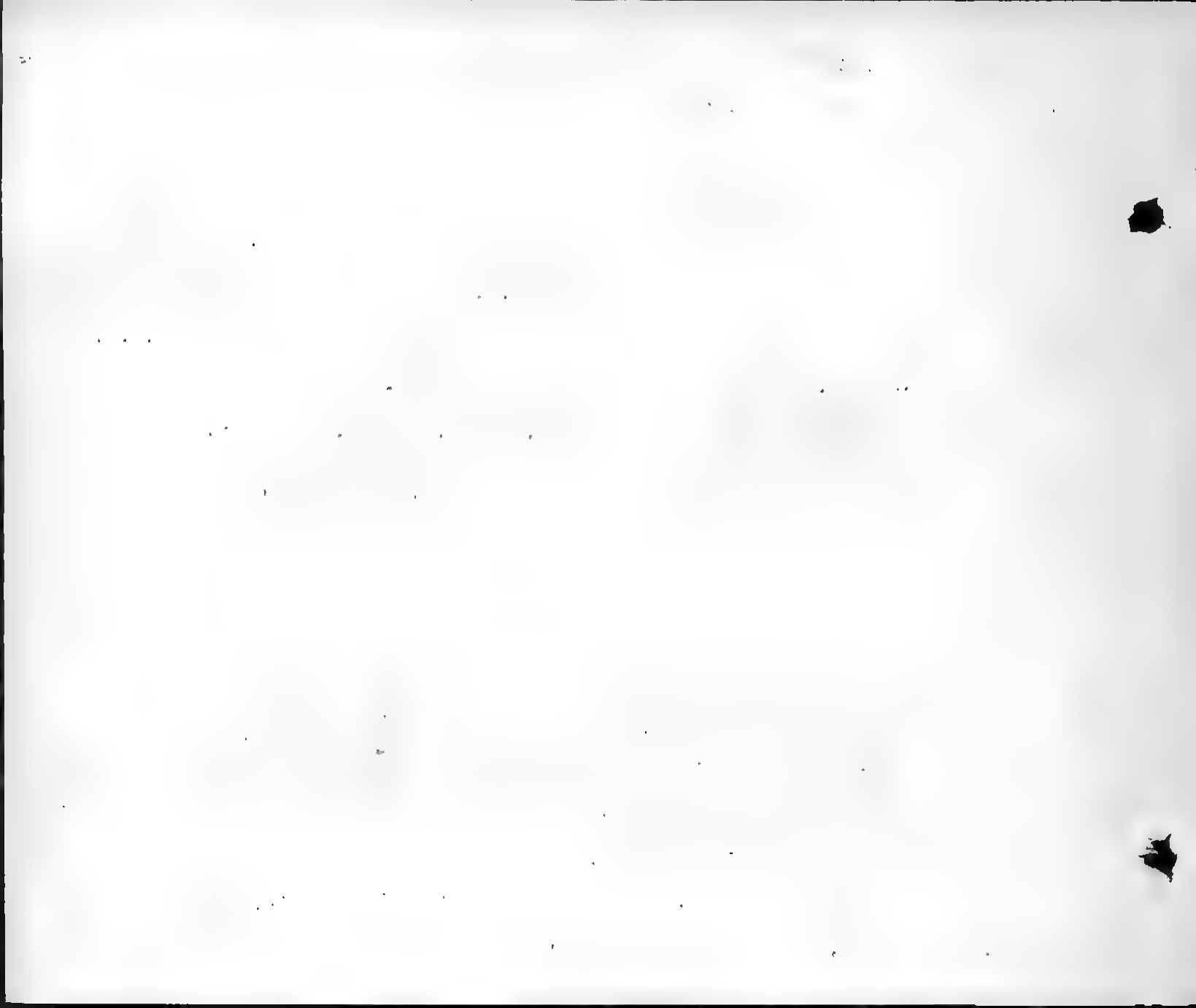
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton, Md		c. LENGTH OF STAY IN 1b X MONKTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Big Falls Road		d. STREET ADDRESS Big Falls Road	
3. NAME OF DECEASED (Type or print) First Howard Middle G Last Wisner		4. DATE OF DEATH SEPT. 16 19 60 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1879
9. AGE (In years and birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Butler, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis T. Wisner		14. MOTHER'S MAIDEN NAME Sarah D. Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service.)		16. SOCIAL SECURITY NO none	
INFORMANT Mrs. Mary L. Walters, Address Monkton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-Cerebral disease 422 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1929 to SEPT. 16 1960 that I last saw the deceased alive on 9/16/60 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Parkeston, Md DATE SIGNED 9/16/60 ACTUAL SIGNATURE A. M. France M.D. PHYSICIAN'S NAME (Type) A. M. FRANCE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-19-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion United Brethern	22d. LOCATION (City, town, or county) (State) Black Rock Road Baltimore County
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook-Towson, Inc., 1050 York Road Towson 4		24a. REC'D BY REGISTRAR DATE SEP 20 '60	24b. REGISTRAR'S SIGNATURE Charles S. France

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10074

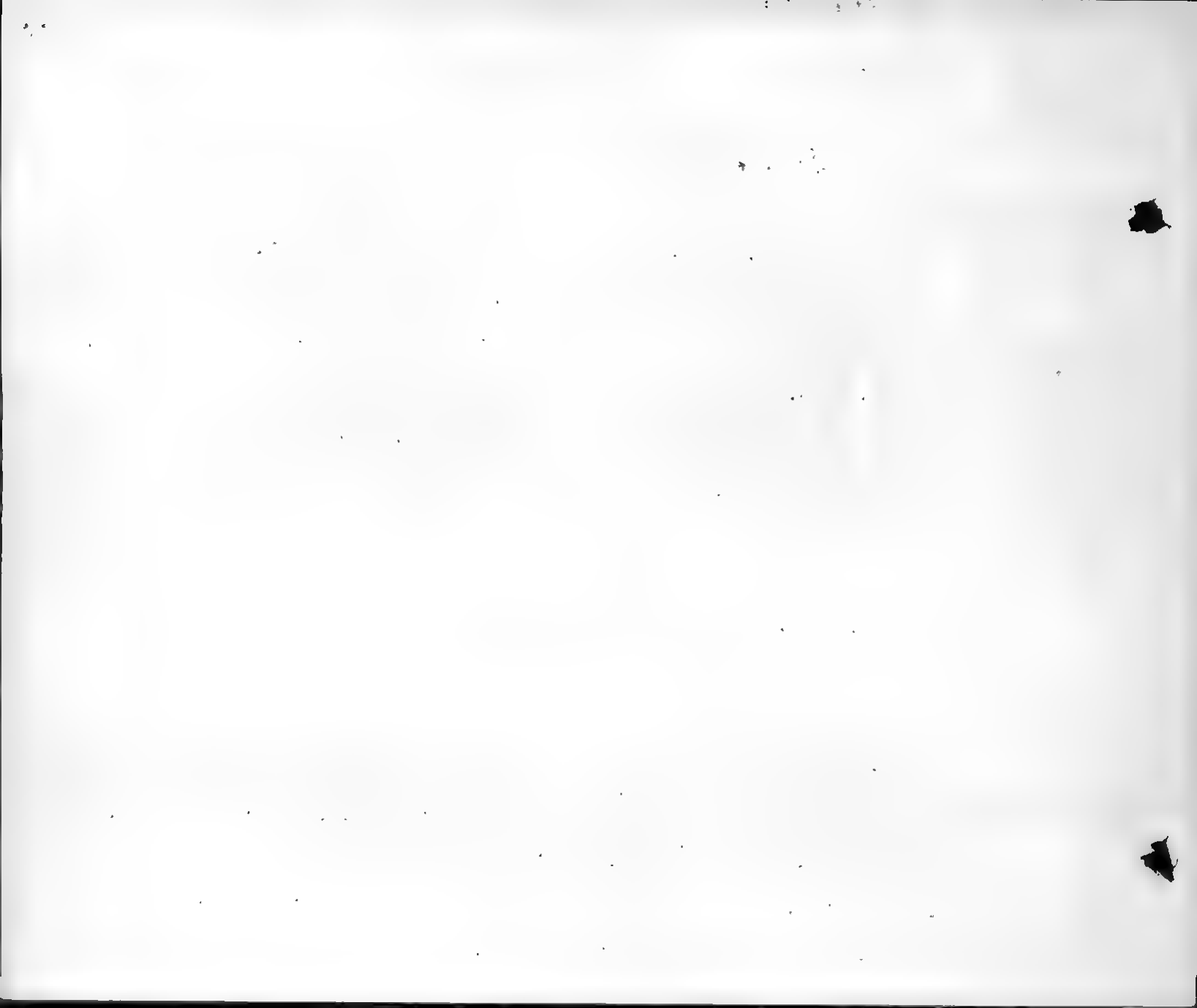
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b Essex d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 640 Rockaway Beech		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX BALTIMORE 21 d. STREET ADDRESS 640 Rockaway Beech e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George A. Wittman		4. DATE OF DEATH Month Day Year Sept. 15, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1885
9. AGE (In years last birthday) yrs 75		10. IF UNDER 1 YEAR Months Days Hours Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY Retired Six Years	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Wittman		14. MOTHER'S MAIDEN NAME Louise Wittman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO INFORMANT 640 Rockaway Beech Avenue Mrs Minnie J. Wittman	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 wk
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to Sept 15, 1960 that I last saw the deceased alive on Sept 14, 1960 and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert J. Lyden, M.D. 815 Eastern Ave 9/17/60. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) ROBERT J. LYDEN, M.D. Balt. 21, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/60	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE SEP 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58



9950

CERTIFICATE OF DEATH

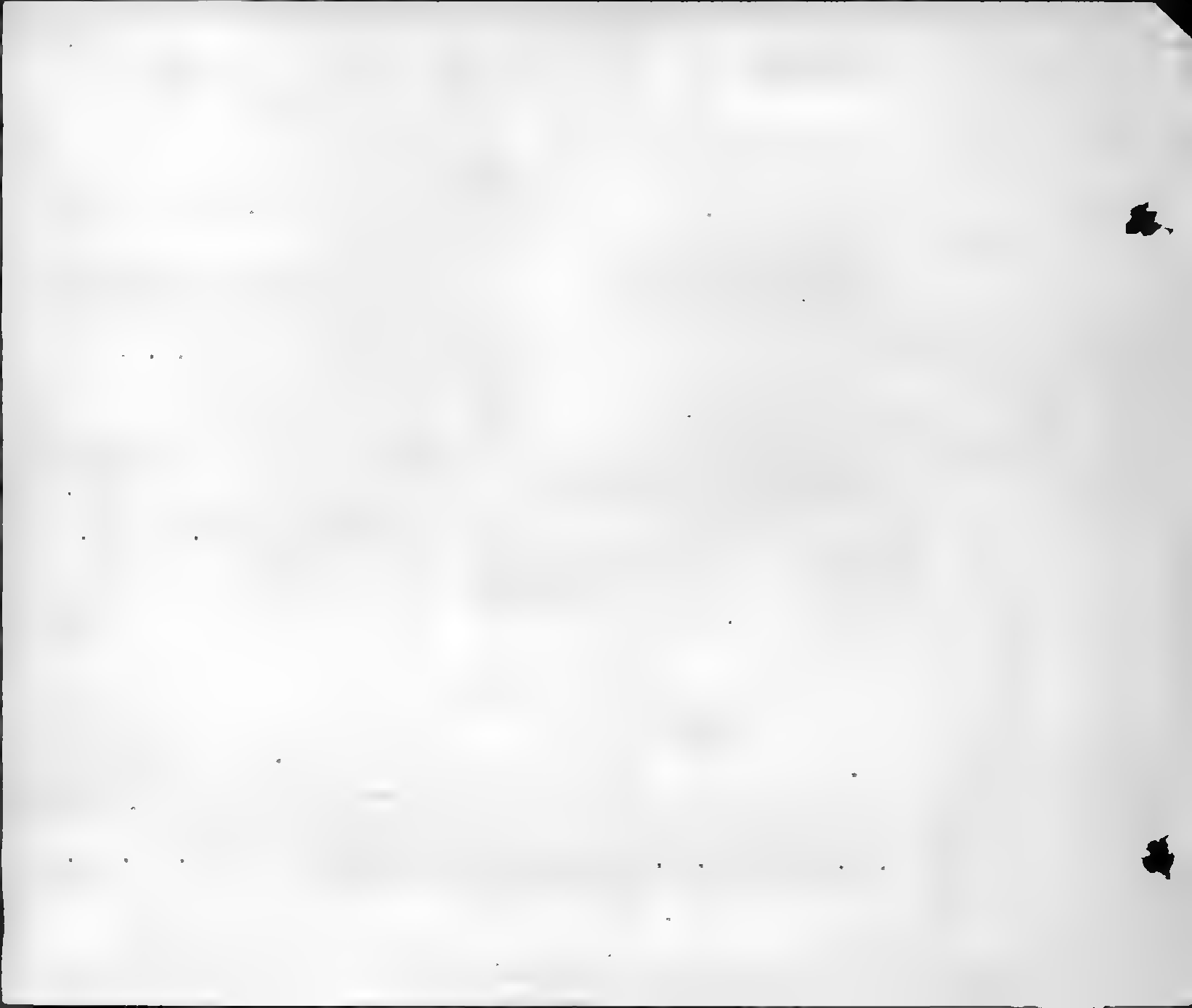
10075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>	
c. LENGTH OF STAY IN 1b <u>29 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2025 Northeast Ave.</u>		d. STREET ADDRESS <u>2025 Northeast Ave.</u>	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Miles Woodford</u>		4. DATE OF DEATH Month Day Year <u>Sept. 11, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mason Miles</u>		14. MOTHER'S MAIDEN NAME <u>Adele ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lucille Woodford</u>		Address <u>2025 Northeast Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>4500</u> DUE TO <u>Chronic venous congestion of lower extrem.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>8 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1955</u> , 19 <u>55</u> to <u>11 of Sept. 1960</u> , that I last saw the deceased alive on <u>11 Sept. 60</u> , 19 <u>60</u> , and that death occurred at <u>9:20 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sept. 14, 1960</u> DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. G. Walden M. D.</u>		2329 Harlem Avenue Balto. 16. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>		ADDRESS <u>3035 W. North Ave.</u>	24a. REC'D BY REGISTRAR <u>SEP 19 1960</u>
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10076

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier, Maryland	
c. LENGTH OF STAY IN 1b 12 days		d. STREET ADDRESS 3204 Shepherd Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Wright Last Wright		4. DATE OF DEATH Month September Day 10 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage; accidental 903.7 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 9-7-60 the patient fell to the floor striking her head	
20c. TIME OF INJURY Month, Day, Year 1:00 9-7 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	20f. (City or town) (County) (State) Catonsville 28, Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		DATE SIGNED 9-12-60	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/14/60	22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATL. Cem.	22d. LOCATION (City, town, or county) (State) SUITLAND, MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Chambers Co</i>		24a. REC'D BY REGISTRAR SEP 19 1960	
ADDRESS <i>Reverdale, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Thomas</i>	

MEDICAL CERTIFICATION

TO BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1007

Blank form with horizontal lines for text entry.

ORIGINAL FILED IN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10102

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10077

Item 7 Film G272 10-6-60 et

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 EASTERN BLVD.		d. STREET ADDRESS 506 EASTERN BLVD (21)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE C WUNDER		4. DATE OF DEATH Month Day Year SEPT. 27 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13-1911
9. AGE (In years lost birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) BALTO. MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JULIUS W HEFNER		14. MOTHER'S MAIDEN NAME LULA RHODE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT PAUL G WUNDER SR. (SAME AS ABOVE)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema-Heart Failure DUE TO (b) Carcinomatosis - Lung DUE TO (c) Carcinoma Breast INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Early 1960 to 9-27-60 , that (I) (we) last saw the deceased alive on 9-27-60 , and that death occurred on 9-27-60 M, from the causes and on the date stated above.			
22a. SIGNATURE John E. Gessner		22b. DATE SIGNED 9-29-60	
22c. PHYSICIAN'S NAME (Type) JOHN E. GESSNER		22d. ADDRESS 701 EASTERN AVENUE, (21)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-30-60	
23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City, town, or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly		25a. REC'D BY REGISTRAR SEP 30 '60	
ADDRESS 418 Eastern Blvd.		25b. REGISTRAR'S SIGNATURE William S. Hanna	

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]